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ABSTRACT

The report of the Illinois commission on Children focuses on the need for developing a comprehensive service plan for emotionally disturbed (ED) children (birth through 21). Emphasis was placed on a continuum of services from prevention to treatment. Findings and recommendations are listed on seven topics (sample suptopics in parentheses): children in need of services (there are no reliable data on the number of ED children in the state); public awareness and support of programs (only 46% of 112 agencies had programs to inform the public of the needs of emotionally disturbed children); legal mandates (there is a lack of specificity regardng legal responsibility for planning, coordinating, or insuring the provision of mental health services for minors); planning for a continuum in Illinios community programs); roles and responsibilities of public and private agencies (there is a lack of a statewide, comprehensive plan agreed upon by both public and private agencies); personnel preparation (state laws and job specifications regarding minimum training are ambiguous and non-specific); and evaluation, accountability, and dissemination (data are collected on a departmental, agency, or institutional level with minimal crossover among departments at the federal/state/community level). Chief among recommendations is a proposal for legislation to create a separate Division for Mentally Ill and Emotionally Disturbed Minors within the Department of Mental Health/Developmental Disabilities. (CL)

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COMMITTEE ON EMOTIONALLY DISTURBED CHILDREN

ILLINOIS COMMISSION
ON CHILDREN

MRS. HELEN WEIGLE,
CHAIRPERSON

Ms. DONNA SIMONSON,
EXECUTIVE DIRECTOR

MISS MARGARET SCHILLING
CHILDREN'S CONSULTANT

JANUARY,
1981

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LETTER OF TRANSMITTAL

TO: Members of the General Assembly
The Honorable James Thompson, Governor
Professionals in the Fields Serving Children with Emotionally Handicapping Conditions
Parents of Children Who Have Emotionally Handicapping Conditions
Concerned Citizens

It is with extreme gratefulness to a dedicated staff and a superb committee composed of members of relevant professions, state agencies and concerned citizens that I wish to offer this report.

After over two years of hard work, great effort and much research in cooperation with both public and private agency personnel, the committee decisions coalesced. Too long, they feel, have children needing service and deserving it gone unserved. Too long have their families had no appropriate place to turn!

It is our earnest hope that the data included in this report will bring all to the same conclusion -- the need for the recommended legislation.

Respectfully submitted,

Helen R. Weigle

Mrs. Helen Weigle, Chairperson
Committee on Emotionally
Disturbed Children

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IL White House Conference on Children

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Mr. Larry D. Vuillemot, Gurnee

VII

COMMISSION ON CHILDREN

The Commission on Children is a Statutory Commission created by the Legislature to provide the mandate, manpower and machinery for the orderly study, planning, promoting, coordinating, and stimulating of services in behalf of Illinois children.

MEMBERSHIP

The membership of the Commission on Children is composed of 16 public members appointed for four year staggered terms, and 6 legislative members, 3 from the Senate, 2 to be appointed by the President and 1 by the Minority Leader thereof and 3 from the House of Representatives, 2 to be appointed by the Speaker and 1 by the Minority Leader thereof and 9 State Department of Division Directors which have direct services to families and children. In addition the Chairman and 2 other designated youth members of the Illinois Council of Youth, which is a represenative body of young people ages 15 to 21, also serve with the Commission.

FUNCTION

The law creating the Commission states the Commission shall:

"(a) Study the needs of all children and assist in planning for the improvement and most effective use of voluntary and tax-supported programs at the state and local levels;
"(b) Study programs for children in Illinois and in other states, make reports and advise public and private bodies throughout the state on matters relevant to the protection, growth, and development of children;
"(c) Assist in the coordination of the administrative responsibility and the services of the State departments and programs as they relate to the well-being of children;
"(d) Make recommendations on needed legislative action on behalf of children;
"(e) Promote adequate educational services and training programs for children, including exceptional children, in all parts of the state;
"(f) Promote social service and vocational guidance, training, and placement for all children who require them, including exceptional children and those youth who leave school prior to high school graduation, and promote adequate special facilities for children maladjusted to their home surroundings;
"(g) Promote adequate provisions throughout the state for diagnosis and treatment of children who may require special medical services."

PROCEDURE

The major part of the work of the Commission on Children is carried on through the use of Special Project Committees which are set up to study, assess, develop and make recommendations to the Commission on specific problem areas concerning children which

are considered to require the priority attention of the Commission and the citizens of the State. After action on these recommendations has been taken by the Commission on Children, the Commission selects and transmits them to the appropriate group, organization or person for implementation. This may be to the Legislature for necessary legislation, to the Governor for Executive consideration, to public agencies, or to citizens of professional organizations.

ACKNOWLEDGEMENTS

The Committee on Emotionally Disturbed Children wishes to acknowledge the contributions of others who provided resource material, working drafts, and technical assistance. Special appreciation is due the following: Ms. Patricia Delaney, Miss Rita Dukette, Ms. Shirley Goins, Mr. Richard Herbig, The Hon. Michael Holewenski, Patricia Hunt M.D., Ms. Mary Kelly, Jeri Kelsay Ph.D., Mr. Frank Kopecky, Frank Rafferty M.D., Bruce Rubenstein, The Hon. Joseph Schneider, Mr. John Schullenberger, Ms. Delia Zemont, David Zinn, M.D., and Miss Sylvia Vedalakis who served as the staff person for the Committee until July of 1980. The Committee is also grateful to the respondents of the two questionnaires sent by two of the subcommittees.

CHAPTER I

Introduction

For some years the state of Illinois has been critically deficient because of its failure to provide adequate services to emotionally disturbed children. On January 8, 1976, a report entitled, Study of Emotionally Disturbed Children, requested by the Governor's Commission on the Revision of The Mental Health Code and prepared by the Commission on Children, was submitted to the Legislature. The report identified critical areas in which services were inadequate and made specific recommendations for further development of services for children in the Illinois Department of Children and Family Services and the Office of Education. The report was favorably received and some of the recommendations have been implemented.

Continuing serious gaps in service cause the Commission on Children to remain concerned about limitations in the public and private resources for detecting and treating emotionally disturbed children in the State and about the placement of many children in facilities for residential care in other states because of lack of adequate facilities in Illinois.

At their November 10, 1977 meeting the Commission recognized a need for a comprehensive plan for serving children who are emotionally disturbed, over and above crisis intervention services. Out of this concern, in January, 1978, the Commission on Children created the Committee on Emotionally Disturbed Children and charged it with the task of developing a comprehensive plan. The charge from the Commission to the Committee was to develop such a plan with particular attention to the following:

1. The legal mandates to the child-serving departments which provide services to emotionally disturbed children;

2. The impact of Public Law 94-142, the Education for all Handicapped Children Act of 1975;

3. The availability and use of children's residential services in Illinois;

4. The availability of community mental health services;

5. A new role for the Institute for Juvenile Research.

The impact of the Education for all Handicapped Children's Act (Public Law 94-142) was significant for the Committee's deliberations.

The Committee noted many problems had occurred as a result of misunderstandings and lack of agreements between the state agencies affected by the Federal legislation and between the State Board of Education and the Washington Offices of Education and Civil Rights.

A positive step to resolve the problems was taken in Illinois when a Memorandum of Understanding was completed on August 26 and 27, 1980 between the Department of Public Aid, the Department of Mental Health and Developmental Disabilities, the Bureau of the Budget, the Department of Children and Family Services, the Department of Public Health, the Illinois State Board of Education, the Department of Rehabilitation Services and the Governor's Office. This Memorandum sets in place a system for governmental agency coordination relating to the functions of the Governor's Purchased Care Review Board. (See Appendix I)

The Education for all Handicapped Children Act, Public Law 94-142 in concert with the civil rights provisions of Section 504 of the 1973 Rehabilitation Act is the entitlement by which all handicapped children are guaranteed a free appropriate public education. P.L. 94-142 speaks to the intent that all handicapped children shall be served in a free and appropriate manner within rubric of RIGHTS for ALL, that the federal government intends to provide upwards of 40% of the excess costs of providing special education service by 1982.

Section 504 of the 1973 Rehabilitation Act speaks to the intent that no agency, public or private, in receipt of federal funds shall discriminate against the handicapped, that the federal Office of Civil Rights shall have in place a system whereby appropriate recourse can be made.

The role of the Juvenile courts as an integral part of the continuum of services to emotionally disturbed children was not considered in the development of this plan.*

Scope of the Study

This study concerns children newborn through age 21 who have severe emotional problems who are not served or who are served inadequately by the existing governmental and voluntary resources in the State. The study also was directed to children placed out of Illinois because of lack of state resources.

In addition, the study examines factors which create stress for families and makes recommendations for alleviating these and other factors which contribute to children's Emotional problems.

The Committee approached this study with concern about the lack of adequate documentation for some child care expenditures. In its final report the Committee emphasized accountability, fiscal implications and priorities for services to children.

Method of Work

The full committee focused on a continuum of services, from prevention to treatment. The following sub-committees were formed to develop findings, make recommendations and report to the full committee:

SUBCOMMITTEE ON PEOPLE WHO NEED SERVICES

Focused on demography to determine the number and location of children currently and potentially emotionally disturbed.

*The Commission on Children, in adopting this Report, decided to study the role of the Juvenile Court as an integral part of the continuum of services to emotionally disturbed children in other activities in the future.

SUBCOMMITTEE ON PROMOTION OF PUBLIC AWARENESS AND SUPPORT OF SERVICES

Focused on studying existing programs for promoting public awareness about emotionally disturbed and behaviorally disturbed children and adolescents and the resources available for them.

SUBCOMMITTEE ON ROLES AND RESPONSIBILITIES OF PUBLIC AND PRIVATE AGENCIES IN THE PROVISION OF SERVICES

Focused on clarification of ways in which public and private agencies can work towards coordinating and planning quality services.

SUBCOMMITTEE ON LEGAL MANDATES

Focused on identifying the statutes, rules and regulation of child serving state departments. Focused on the gaps in the legal mandates in relation to services.

SUBCOMMITTEE ON EVALUATION, ACCOUNTABILITY, AND DISSEMINATION

Focused on clarifying the major components of program evaluations as these should apply to the various programs.

SUBCOMMITTEE ON TRAINING

Focused on reviewing current training programs and resources for the disciplines involved in the care, education and treatment of emotionally disturbed children and their families.

Monthly meetings were held by the full committee from January, 1978 through July, 1980 to allow members of the committee to study reports of the subcommittees and to develop recommendations concerning services to emotionally disturbed children. The Committee adopted the following definition of emotionally disturbed children:

Emotionally disturbed children are those from birth to twenty-one whose feelings, reactions or behavior prevent or interfere substantially with normal growth and development.

Child serving departments in Illinois, private agencies, schools, associations, and other organizations were contacted to obtain or clarify information about their current policies, practices and statistics and about current laws to identify factors that relate to services for emotionally disturbed children. Material was obtained from research, reports from other states and committee discussion. In addition, subcommittee members conducted several surveys in Illinois for information about public awareness programs, training and expectations of private and public agencies.

CHAPTER II

CHILDREN AND FAMILIES WHO NEED SERVICE

Background

The state of Illinois has no master plan for coordinating services to children and adolescents. No one knows the exact numbers or locations of emotionally disturbed children except as they are reflected in statistics about services offered. In addition, there is no central conduit for the receipt of statistics which can be cross-collated among the code agencies and other resources. Services for children and adolescents have been planned on the basis of existing programs and funding sources rather than on the overall need of emotionally disturbed children.

The basic value judgement underlying this study has been a strong belief in the value of the family. This implies the need for strengthening the mental health of families as well as their children through schools and other local agencies. Concomitantly, the community itself must be strengthened in order to undergird family stability and to meet individual and family special needs. Our basic commitment is to the right of the child to the highest level of health attainable. The task of developing comprehensive mental health services for children is primarily one of efficient interdigitation, not the formulation of a hierarchy of resources.

Definition

There is a myriad of definitions for the term "emotionally disturbed children." Among all of the documents reviewed there are no standard definitions and in many monographs no definition whatsoever. For the purpose of this report the Committee agreed that the definition should include a broad spectrum of dysfunctioning children as well as those at high risk. Therefore, emotionally disturbed children are defined as "those whose feelings, reactions or behavior prevent or interfere substantially with normal growth and development."

Findings

I. The State of Illinois has no master plan for coordinating services to children and adolescents, including those who are emotionally disturbed.

II. There are no reliable data which yield the number of emotionally disturbed children in the state. The only children counted are those who are being served. Even for these children, there is no central conduit for receiving and collating statistics from mental health agencies.

III. For twenty years, the National Institute for Mental Health (NIMH) has been refining census items which reflect potential high risk factors for mental illness. This process is called the Mental Health Demographic Profile (MHDP).

The original 130 factors have been reduced to thirty variables which have been found to correlate with an increased incidence of emotional disabilities and substance abuse. These factors are associated with, but not causative for, emotional disability and as such offer a demographic base for anticipating unmet needs.

Certain mental health associations have applied these data to their local communities but apparently no statewide application of these social area dimensions (SAD) has been made.

IV. Most estimates of the prevalence rate of emotionally disturbed children range from 2% to 5% of the population under 21.* On the basis of the statistics in Volume 1 of "The State of the Child" there were 3,883,000 children in Illinois in 1979.* Two percent of this figure would be 77,660; 5% would be 194,150. The President's Commission on Mental Health estimated 13% of all persons receiving mental health services received out-patient treatment by psychiatrists and psychologists in private practice.** On the basis of statistics to follow approximately 333,337 children were served by code agencies in 1979. However, since these agencies statistics include many children who are not emotionally disturbed, it is unlikely that all of the emotionally disturbed children in Illinois are being served.

V. A research project sponsored by the School of Social Service Administration at the University of Chicago, Public Policy and Services for Children, reports that "virtually all of the data collected by public and private agencies are narrowly oriented...We are virtually ignorant of the conditions of children who have remained outside of the organized service network."

VI. Among agencies in Illinois charged with serving children with emotional difficulties there are many inter-agency differences in reporting, in definitions and in programming. This handicaps community-wide planning. There is variation about age grouping for eligibility, service and reporting, with many tracking only to 18 and others to 21.

VII. According to statistics from the Department of Mental Health and Developmental Disabilities, reporting on children served in state agencies and in grant-in-aid programs, including community clinics, 54,830 children 21 years and younger were served in fiscal year 1978. There is no mention of children in need but not being served, although the department has endorsed the delivery of services to children and adolescents as one of its primary goals, duties and responsibilities. That department's definition of "children in need" is limited to those who are mentally ill or developmentally disabled.

*Testa, Mark; Wulczyn, Fred; The State of the Child, The Children's Policy Research Project, School of Social Service Administration, the University of Chicago, Chicago, 1980, page 56, page 3.

**Task Panel Reports Submitted to the President's Commission on Mental Health, Volume II, Appendix, U.S. Government Printing Office, Washington, DC, 1978, page 530.

VIII. The Department of Children and Family Services' statistics show that 24,807 children were reported to be abused or neglected during 1979.* In this department, especially, children are served by virtue of available programs rather than immediate need.

IX. The Department of Corrections reports approximately 1,000 children were served in 1979; one-third of these show specific need in the educational area. Evaluation of this figure is complicated by variations in definition of the problems of the children being served.

X. According to the State Board of Education, approximately 250,000 children are being served in special education programs; the percentage that should be considered emotionally disturbed is unclear since they may be counted in other categories.

XI. There are significant omissions in the available data.

a. Accurate statistics for children under five years of age and over 18 are not available. High risk infants are increasingly being recognized and treated. The American Academy of Pediatrics estimates that between 5 and 10% of these children will have "significant permanently handicapping conditions."
b. A study of grant-in-aid mental health clinics revealed limited service to children and inadequate linkage with children being served by PL 94-142 but did not reveal the extent of this deficiency.
c. Many private agencies serving children and adolescents, especially the Youth Services, keep in-house statistics which are never reported to outside sources.

XII. There is no statewide planning or research group charged with surveying and coordinating the needs of children and the efforts to meet those needs by each and all providers of services.

XIII. There is a lack of emphasis on preventive mental health services. The State is, in fact, not adequately covered for preventive physical health.

RECOMMENDATIONS

1. that there be a continuing effort to standardize the definition of "emotional disturbance." The myriad of definitions add confusion to both planning and programming. The definition should include children at high risk as well as those who already manifest the signs and symptoms of mental illness.
2. that the Illinois Department of Mental Health and Developmental Disabilities expedite the application of the 1980 census data for purposes of anticipating the number of children at high risk as reflected in the social area dimension factors developed by National Institute for Mental Health. This should be done with help from a NIMH consultant. (See appendix II relative North Central Region census data.)

*IL Department of Children and Family Services, 1981 Plan, Phase I 1979-81 Human Services Data Report, page 33.

3. that a state-wide planning group be set up, to plan for services for children prior to the budget review process with the IL Commission on Children being responsible for convening the first meeting. Personnel should include experts in statistics and demography. Statistics need to be collected which will be helpful for planning services for children.

4. that statistical reporting be made compatible among the reporting agencies in the interests of expediting services by all child serving agencies. The use of the new American Psychiatric Association Diagnostic & Statistical Manual III categories should be considered. The Division of Information and Referral of DMH/DD shall be consulted.

5. that the IL Commission on Children should be in continuing dialogue with the research program, Public Policy and Services for Children at the School of Social Service Administration of the University of Chicago, in order to use the results of these studies.

6. that preventive mental health programs be integrated into the planning for children with emotional disturbances. Basic to these efforts is a continuum of public health resources available to all children throughout the state.

7. that Health System agencies work on coordination for purposes of planning and service delivery.

CHAPTER III

PUBLIC AWARENESS AND SUPPORT OF PROGRAMS

Background

The viability of programs to serve emotionally disturbed children and their families depends upon public awareness of the problems presented by such children. It is a professional responsibility to make consumers aware of the existence of these services. More effective early use of appropriate services could result in interventions at a lesser level of the child's disturbance and in the need later for more costly intensive hospitalization and residential treatment. The next step goes beyond awareness to public willingness to commit resources to provide programs and services necessary to solve the problems of emotionally disturbed children and their families. Finally, after programs are in place it is the responsibility of the public to monitor them. Citizens and citizen groups should ask the following questions on a continuing basis:

- Are programs achieving desired results?
- Are sufficient resources being allocated to the programs?
- Are adequate provisions being made to prevent and overcome problems which make the programs necessary?
- Is a syster in place for phasing out unneeded programs or adapting present programs to changing needs?

Another important aspect of public awareness is information about the availability of services for emotionally disturbed children and their families. This includes not only information concerning education and treatment programs but screening programs which lead to the early identification of children with problems. These efforts must be ongoing.

Until the late forties and early fifties, the movement to provide better services for emotionally disturbed children and their parents was spearheaded primarily by philanthropists, professionals and bureaucrats. At that time, parent groups became active and organized around various categories of handicap. In the beginning these groups initiated programs for their children which they funded and managed themselves. Through lobbying, litigation and cooperation with professional groups these parent organizations played a major role in passing legislation mandating special education for all handicapped children during the middle sixties and early seventies. Illinois House Bill 1407 of the 73rd General Assembly was passed in 1965, mandating special education for handicapped children of all types by 1969. Other states followed Illinois' lead and these efforts culminated in the passage of Public Law 94-142, signed into law by President Ford on November 29, 1975, the intent of which is to provide a "free appropriate education" for all handicapped children.

Unfortunately, the parents of emotionally disturbed children have played a small part in this effort. This is probably due to the lack of public acceptance of mental illness. It is also possibly related to family stress or to having a child with "mental" or "social" problems. There is also less clarity in the identification of such problems. Although there are many programs for handicapped children, there is need for expanded services to emotionally disturbed children.

Findings:

I. A questionnare was sent to 160 agencies serving children. From 112 (70% of return rate) responses, it was learned that 81% of the responding agencies have direct service programs for emotionally disturbed children but only 46% have programs to inform the public of the needs of emotionally disturbed children and the services available to them. (See appendix III for questionnaire and tabulation.)

II. The following concerns were expressed by respondents:

a. Specialized clinical and educational services in Illinois and facilities of all types are either lacking, inadequate, inaccessible, or unevenly distributed;
b. There is a critical lack of state supported residential facilities so that many children continue to be sent out of state for care;
c. There is a dearth of support systems and staff development and consultation services and of interdisciplinary training;
d. There is a serious paucity of adequately trained and/or supervised professional personnel clinically and educationally qualified to deal with the diverse and complex needs of emotionally disturbed/behavior disordered children and their families;
e. Lack of adequate funding affects all types of programs, particularly prevention programs, services to adolescents and programs to increase public awareness of needs and services;
f. Gaps in services, inconsistency, discontinuity, unevenness, lack of cooperation, coordination, communication characterize the service;
g. Gross inadequacies exist at all levels of care and there is need for a systems approach to planning, funding and service delivery.

III. There are some inherent difficulties in developing public awareness programs concerning emotionally disturbed children.

a. Parents are likely to make premature and subjective decisions about whether or not a child has a specific problem. Screening programs should not be limited to those children for whom parents consider it needed.
b. School board members and school administrators may be reluctant to expand public information activities out

of concern that demands for services already in limited supply will be increased, causing even further public dissatisfaction;

c. Parents' reluctance to be identified as having a child with emotional problems limits the advocacy efforts of this group, as contrasted to the parental efforts for learning disabled or physically handicapped children;

d. Lack of consistency in the nature and extent of public information from one agency to another and results in making the public over-confident or skeptical;

e. A continuing misunderstanding in educational circles of the range of behavioral manifestations of emotional disturbance retards the development of improved services for emotionally disturbed children.

RECOMMENDATIONS

1. that organizations which advocate for all handicapped children place a special emphasis on the unique need of emotionally disturbed children and their families.

2. that the State Board of Education and the Code departments serving children develop an integrated public awareness program designed to educate the public concerning the nature of emotional disturbance in children and the services which are available to them and their families with special emphasis on eliminating the stigma attached to emotional disturbance.

3. that local school districts, cooperative and regional special education programs be required to develop in cooperation with social service and health agencies in the public and private sectors, an integrated public awareness program on the needs and nature of emotionally disturbed children and a directory of services and referral procedures for emotionally disturbed children and their families.

4. that the Illinois Mental Health Association and all other organizations concerned with Mental Health place emphasis on making the public aware of the needs of emotionally disturbed children and their families.

CHAPTER IV

LEGAL MANDATES

Background

A legal mandate is the means by which the legislature seeks to meet a societal need; a Department or Agency of the state or federal government is given specific instruction by law in order to address problem situations. State agencies are required by law* to have rules for implementing the statutes made available for public inspection and are filed with the Secretary of State. The state agencies must:

. base the rules on the appropriate statute;

. publish rules in the Illinois Register with a period for public comment;

. make the rules uniform throughout the state.

Problems to be addressed in a legislative manner are part of this chapter, as well as administrative recommendations relative to the major departmental responsibilities.

The following legal mandates** are those relating primarily to children and are not all inclusive. They reflect the extensive legislation in Illinois on behalf of children and families and the broad concerns of its citizens.

Illinois Department of Mental Health and Developmental Disabilities

The statutory authority of the Department of Mental Health derives from:

IL REV. STAT. 1977, ch. 91-½, §100-1 et. seq., "Powers and Duties of the Mental Health Department"
IL REV. STAT. (Supp. 1978, ch. 91-½, §1-100 et. seq., Mental Health and Developmental Disabilities Code)
IL REV. STAT. 1977, ch. 91-½, §100-71 et. seq., "Mental Health Zone Centers Act"
IL REV. STAT. 1977, ch. 91-½, §120.1 et. seq., "Dangerous Drug Abuse Act"
IL REV. STAT. ch. 91-½, §501 et. seq., "Alcoholism and Intoxification Treatment Act"
IL REV. STAT. ch. 91-½, § 601 et. seq., "Specialized Living Centers Act"
IL REV. STAT., ch. 91-½, §701, "Guardianship and Advocacy Act"
IL REV. STAT., Ch. 127, §53 and 53a, "The Department of Mental Health"

*Administrative Procedures Act, Chapter 127, Section 1004, 1979 Illinois Revised Statutes.

**The work of the Committee on Emotionally Disturbed Children on 'Legal Mandates was enhanced and supported by the Report to the Illinois General Assembly on Code Revision, July, 1980, Commission to Revise and rewrite the Public Aid Code.

The Department is responsible for accepting and providing services for persons admitted to a mental health facility for treatment of mental illness. Article V. of the M.H. Code Sect. 3-500 indicates that a minor may be admitted to a mental health facility for "treatment of a mental illness or emotional disturbance..."

ARTICLE V. ADMISSION OF MINORS

3-500. Admission procedure--Restrictions

§3-500. A minor may be admitted to a mental health facility for treatment of a mental illness or emotional disturbance only as provided in this Article or as provided in Section 3-10-5 of the Unified Code of Corrections, as now or hereafter amended.

(Chapter 38, 1003-10-5.)

Section 100-7 of the powers and duties of the Mental Health Department provide that patients seventeen years of age and under be housed in quarters separate from older patients:

100-7. Care and treatment

§7. To receive and provide the highest possible quality of humane and rehabilitative care and treatment to all persons admitted or committed or transferred in accordance with law to the institutions, divisions, programs, and services under the jurisdiction of the Department. All patients of 17 years of age and under in residence in a Department facility other than a facility for the care of the mentally retarded shall be housed in quarters separated from older patients except for: (a) patients who are placed in medical-surgical units because of physical illness; and (b) patients between 13 and 18 years of age who need temporary security measures.

All patients in a Department facility shall be given a dental examination by a licensed dentist or registered dental hygienist at least once every 18 months and shall be assigned to a dentist for such dental care and treatment as is necessary.

All medications administered to patients shall be administered only by those persons who are legally qualified to do so by the laws of the State of Illinois. Medication shall not be prescribed until a physical and mental examination of the patient has been completed. If, in the clinical judgement of a physician, it is necessary to administer medication to a patient before the completion of the physical and mental examination, he may prescribe such medication but he must file a report with the Superintendent setting forth the reasons for prescribing such medication within 24 hours of the prescription. A copy of the report shall be part of the patient's record.

Amended by P.A. 78-1297, §28, eff. March 4, 1975.

Section 100-7.1 provides for assistance to families of mentally ill children who must be placed in private facilities:

100-7.1 Assistance to families in placing mentally ill children--Supplemental payments by Department.

§7.1 To assist families to place mentally ill children, for whom no appropriate care is available in Department facilities, in licensed private facilities, the Department shall supplement the amount a family is able to pay, as determined by the Department and the amount available from other sources, provided the Department's share shall not exceed a uniform maximum rate to be determined from time to time by the Department.

Added by P.A. 76-1943, §1, eff. Oct. 13, 1969.

The Institute for Juvenile Research operates under Section 100.11:

100-11. Institute for Juvenile Research--Maintenance and operation.

§11. To maintain and operate the Institute for Juvenile Research. The Director shall appoint a qualified person as superintendent of the Institute, and such other employees and assistants as may be necessary to conduct scientific studies, diagnose and promote the treatment of children who are delinquent, emotionally disturbed, mentally ill, mentally defective or socially maladjusted or who are in danger of becoming so, to the end that delinquency, crime, mental disorders and other forms of human maladjustment may be prevented. The Institute shall make personal examination and social studies of such children in the custody or under the control of the Department or of any court, school, public or private social agency or parent or guardian.

Section 100.11 provides for special education services for all patients living in state mental health facilities between the ages of 5 and 21:

Section 11.1. Special Education Services--Report. To provide for all patients living in state mental health facilities between the ages of 5 and 21 years special education services, as defined by the Department of Mental Health and Developmental Disabilities to the extent that such services are practical for each child's needs. Upon discharge of the child, a report of the discharge, accompanied by a report on the special education services received by that child while in the institution shall be forwarded to the Office of Public Instruction and to the resident school district. (This section added by SB 1114 approved October 13, 1969, and amended by PA 78-992 (HB 785), approved July 2, 1974, effective October 1, 1974.)

Section 100-34 authorizes the Department to make grants-in-aid to community clinics for psychiatric or clinical services, training and research.

Article II, section 3-200 of the Mental Health Code provides for transfers by the Department of Corrections.

> 3-200. Admissions--Transfers by Department of Corrections--Release
>
> §3-200. A person may be admitted as an inpatient to a mental health facility for treatment of mental illness only as provided in this Chapter, except that a person may be transferred by the Department of Corrections pursuant to the Unified Code of Corrections, as now or hereafter amended.[1] A person transferred by the Department of Corrections in this manner may be released only as provided in the Unified Code of Corrections, as now or hereafter amended.
>
> [1]Chapter 38, 1001-1-1 et seq.

Major Findings:

I. There is no statement of responsibility in the legal mandates of DMH/DD for planning, coordinating or insuring the provision of mental health services for minors.

a. There is no definition of mental illness or emotional disturbance in the Mental Health and Developmental Disabilities Code.
b. The guidelines and interpretations as to which minors are eligible or appropriate for mental health services provided directly or indirectly by DMH/DD are too restrictive. This has resulted in denial of service for many severely disturbed minors.
c. Common experience of professionals and others in both state and community agencies is that it is extremely difficult to obtain mental health services for minors. Decisions as to which minors are eligible and appropriate for services varies considerably throughout the state.
d. No statistics are available to 1) show which minors are rejected by DMH/DD or community mental health clinics or 2) to show the reasons for rejection or 3) to show that alternate plans were considered and recommended.
e. Aftercare planning and monitoring of care and treatment of minors who are discharged from DMH/DD is haphazard or frequently does not occur.
f. DMH/DD has given no priority to children's services in the grant-in-aid clinics. These clinics operate differently from one place to another and services for minors are unevenly developed throughout the state.
g. The Institute for Juvenile Research as it currently functions is not carrying out its statewide mandate for children.

MAJOR RECOMMENDATIONS

1. that the Legislature enact a law creating a separate Division for Mentally Ill and Emotionally Disturbed Minors within the DMH/DD.

. that the Division have an Associate Director appointed by the Director of DMH/DD with consent of the Senate.
. that the Institute for Juvenile Research be incorporated in the Division.
. that the Division be the lead agency for planning and coordinating mental health services for minors on a statewide basis and have the responsibility for insuring that other services are available as necessary. (The proposed bill is at the end of this chapter.)

2. that this proposed legislation provide a mechanism for insuring coordination of comprehensive services for severely disturbed minors so that every source of service and funding is used when the minor's problems are multi-dimensional and require multiple services. It is recommended that there be interagency agreements for high risk populations to facilitate the comprehensive planning required by the child. This is to include a good case management system. (A model for a pilot project is in appendix IV.)

3. that there be a separate line item in the budget of the DMH/DD for minors. The proposed division is to have its own administrative budget including a budget for Individual Care Grants. The division is to work with the regional administrators of DMH/DD in development of budgets for services to minors.

Additional Findings:

I. Because of limited purpose and funding the Individual Care Grant program cannot be an effective stimulus for private programs to develop new and better residential treatment programs for minors who might otherwise be hospitalized.

a. Department of Mental Health/Developmental Disabilities accepts little responsibility for serving minors with emotional disorders which require a residential treatment facility rather than hospitalization. Department of Mental Health/Developmental Disabilities limits the placement of minors in Individual Care Grant placements to those who are mentally ill according to its definition and for whom the Department does not have an in-patient facility.
b. As a result of the limited in-patient facilities in DMH/DD and limited funding for Individual Care Grants, families are left to wander between DMH/DD, Department of Children & Family Services (DCFS), the public schools and Juvenile Court to seek assistance with planning and funding. This results in many children unserved or underserved.
c. Voluntary agreements with DCFS are being misused in order for some children in need of mental health services to receive them.

II. Residential treatment facilities for mentally ill and emotionally disturbed minors who have delinquent and behavioral symptoms are very limited in Illinois. Programs for the most difficult minors are but rarely provided by interagency

projects. An exception to this is the Tri-Agency program at Tinley Park Mental Health Center which is for a limited number of adolescent boys only.

III. There is one program in the private sector for providing a range of residential treatment resources for severely emotionally disturbed, acting out, multi-problem adolescent boys and girls: the Joint Service program for adolescents is administered by Comprehensive Community Services, an affiliate of United Way and limited to DCFS wards. This program is a joint effort of participating private agencies who have developed new programs and techniques to meet the specific needs of a limited number of adolescents.*

ADDITIONAL RECOMMENDATIONS

1. that the budget for individual care grants be substantially increased for Fiscal Year 1982 so that the narrow interpretation of children eligible can be expanded.

2. that the Department of Mental Health/Developmental Disabilities should assume responsibility immediately as the lead agency in planning and coordinating services for mentally ill and emotionally disturbed children who may require residential treatment or hospitalization.

3. that the DMH/DD assist families in planning and implementing alternative plans when these are desirable.

4. that the DMH/DD and community mental health clinics discourage referrals to the Department of Children and Family Services for voluntary applications when the primary problem is mental illness or emotional disturbance and neglect is not active or incipient. The committee reinforces a long held premise of the Commission on Children that parents should not be required to declare that a child is neglected in order to be eligible for services.

5. that the DMH/DD assume leadership on an administrative basis to work cooperatively with DCFS and DOC to extend the Tri-Agency concept to a program for girls and additional programs for boys. Planning should begin immediately for Fiscal Year 1982.

6. that the DMH/DD assume a leadership role in working with DCFS, Department of Corrections and appropriate community agencies to develop funding resources to extend the concepts developed by the Joint Service Program for Adolescents to other areas of the state and to extend it to seriously disturbed minors whose problems are multidimensional but who are not wards of DCFS.

*Executive Summary of Exploratory Evaluation of the Joint Service Program for Adolescents. The United Way of Metropolitan Chicago, July, 1980.

Illinois Department of Children and Family Services

The Department of Children and Family Services is responsible for providing services to individuals and families to:

. Protect and promote the welfare of children and to strengthen their families;
. Prevent, remedy or assist in the solution of problems which may result in the neglect, abuse, or exploitation of children;
. Protect and care for homeless, dependent or neglected children;
. Provide adequate care of children away from their homes.

It operates under the following statutes:

IL REV. STAT., ch. 23, §5001, et. seq., "Department of Children and Family Services"
IL REV. STAT., ch. 23, §2051 et. seq., "Abused and Neglected Child Reporting Act"
IL REV. STAT., ch. 23, §2211 et. seq., "Child Care Act"
IL REV. STAT., ch. 37, §701 et. seq., "The Juvenile Court Act" *

The Department of Children and Family Services operates under a current mandate to provide child welfare and supplemental services to emotionally disturbed children if they are neglected or dependent, or if they are minors in need of supervision under the age of eighteen and have violated an order of the court, or if they are committed to DCFS as delinquents and are under the age of thirteen.

In addition, note should be taken of the recent amendments to Section 5003 of Chapter 23, IL REV. STAT.; effective July 1, 1978, which imposes upon DCFS a responsibility to individualize its treatment for all wards. That section reads as follows:

> "If the Department finds that there is no appropriate program or facility within or available to the Department for a ward and that no licensed private facility has an adequate and appropriate program or none agrees to accept the ward, the Department shall create an appropriate individualized program oriented plan for such ward. Such a plan may be developed within the Department or through purchase of services by the Department to the extent that it is within its statutory authority to do so."

Findings:

I. The use of voluntary applications and court adjudications of neglect and dependency are being misused when the paramount problem is severe emotional disturbance and neglect is not active or incipient. This occurs in an effort to obtain services and funding when these are denied by DMH/DD.

*At the request of the Department of Children and Family Services the full text of these statutes is in appendix X.

RECOMMENDATION

1. It is recommended that the Committee reaffirm the position of the Commission on Children that parents should not be required to declare that the minor is neglected or dependent in order to obtain assistance for their severely disturbed children and that DMH/DD develop a mechanism to review such cases and coordinate their efforts and resources to serve such families.

Illinois Department of Corrections

Acting under the Unified Code of Corrections the Department is responsible for care, custody, treatment and rehabilitation of adults and juveniles committed to the department by the courts of the State of Illinois.

Service goals are to assist individuals to avoid further criminal involvement and to become self-sufficient.

The statutory authority for the Department is:

IL REV. STAT., ch. 38, §1003-1-1 et. seq., "Department of Corrections"
IL REV. STAT., Ch. 37, §701 et. seq., "Juvenile Court Act"

The Unified Corrections Code established a Juvenile Division to be administered by an assistant director appointed by the Director and confirmed by the Senate.

Section 1003-9-2 DOC may provide for work training programs for Juveniles. Section 1003-9-3 DOC may provide for juvenile day release programs in schools, agencies, and participation programs. Other services which may be established are:

1) halfway houses
2) employment counseling, job placement and assistance in residential placement
3) family and individual counselling
4) vocational and rehabilitation counselling and placement
5) establishment of community centers to facilitate transition of offenders into normal community living.

The Department of Corrections has an identifiable public school district. The statutory authority for the School District is:

IL REV. STAT., Ch. 122, Article 13-40 to 45.

The purpose of the district "is to enhance the quality and scope of education...so that inmates and wards will be better motivated and better equipped to restore themselves to constructive and law abiding lives in the community" (Section 13-40).

The school district is authorized to establish primary, secondary, vocational adult, special, and advanced educational programs. Special education programs are now being provided by Lincoln Land Special Education Systems.

Finding:

I. Sufficient closed treatment facilities are not provided either by DOC or DMH/DD for severely disturbed, delinquent, behaviorally disordered minors who require a therapeutic setting.

a. The Unified Code of Corrections and the Mental Health and Developmental Disabilities Code have a procedure for transfer of mentally ill minors between DOC Juvenile Division and DMH/DD. Those minors who are too assaultive for traditional mental health settings and persons whose behavior is too bizarre for community tolerance often do not meet mental health commitment criteria. Treatment needs of such minors are not being met in either correctional or mental health resources.
b. DOC has difficulty in obtaining services from DMH/DD for minors with severe mental or emotional problems. There is a morass of red tape and rejection which is exemplified by minors being returned to DOC on the very day of admission to a DMH/DD facility. This occurs with both voluntary and involuntary admissions despite extensive documentation of psychopathology.
c. The Tri-Agency Program at Tinley Park Mental Health Center is an effort to provide services for those minors who cannot be served entirely by DOC, DMH/DD or DCFS. The program serves a limited number of boys whose problems are multidimensional and require mental health, child welfare and correctional services. This program does not serve girls although this has been previously recommended by the Commission on Children.

RECOMMENDATION

1. that DOC, DMH/DD and DCFS cooperatively develop a program for girls and additional programs for boys based on the concepts of the Tri-Agency program. This is a priority and planning should begin immediately, including specific planning for follow-up and evaluation.

Illinois Department of Public Aid

This Department has responsibility to assist individuals and families achieve a standard of living above poverty levels through services that aim to:

. Provide economic support
. Provide casework to reduce dependency
. Prevent abuse, exploitation, neglect of persons unable to protect their own self-interests.

The statutory authority is:

IL REV. STAT., 1979, ch. 23, Sec. 1, public aid code.

Mandated social services are:

. Guidance and counseling;
. Rehabilitative services to the extent that the local office staff must encourage and assist applicants and recipients to make maximum use of public or private agencies providing such services;
. Educational services to the extent that the local offices must cooperate with public and private education vocational and training and retraining agency.

Finding:

I. The department has no legal mandate and no Rules and Regulations which apply only to the emotionally disturbed. The eligibility criteria for assistance programs, benefits and social services described in the Public Aid Code apply to all children. There are many children submerged in the public aid caseload whose emotional problems go unattended until they come to the attention of the Juvenile Court, the DCFS, the DMH/DD and DOC. The records of all these agencies reflect the high proportion of children who come from families on public assistance.

RECOMMENDATION

1. that the Department of Public Aid strengthen and implement the mandated social services and develop strong liasons with all child serving agencies so that minors in need of mental health services will be detected as early as possible and appropriate interventions occur.

Department of Public Health

The statutory authority is:

IL REV. STAT. 1977, ch. 127, § et. seq., "Act creating the Department of Public Health"
IL REV. STAT. ch. 111-½, § et. seq., "Public Health"

Mandated social services:

In general the department does not directly administer any cited "social service" programs. The department does formulate rules and regulations for various statutorially-created health programs which health care facilities must follow. The Department is mandated to establish many programs and regulations which foster better health care service to the citizens of Illinois. Since the line between health and social services is difficult to draw, the following "Health" services are listed. Many of these have an outreach or counseling component.

1. The Phenyketonuria Screening Program (PKU) mandates that every newborn be checked for the disease, ch. 91, 113 (f)-(h).

2. The department makes and enforces rules and regulations for the licensing of blood banks. ch. 111-½, 601-101.

3. The department inspects and provides regulations for the establishment of migrant labor camps. ch. 111-½ 73-1 et. seq.

4. The department investigates and provides educational materials on venereal disease. ch. 91, 113a-113c.

5. The department must regulate and establish immunization programs for children. ch. 11-½, 22, 22.11, 22.12, 24.

6. The Renal Disease program offers technical and financial assistance as a supplement to other resources. ch. 11-½, 22.31-21.33.

7. The department assists local health agencies by providing them with vaccine for any compulsory immunization program. ch. 127, 55-13.

8. The department provides help for areawide planning for hospital emergency services to rape victims. Hospitals licensed by the Department are required to participate. ch. 111-½, 87-1 through 87-9.

9. The department must establish program for hemophilia treatment of eligible persons at designated hemophilia centers. Financial assistance is granted if no other resources are available. ch. 111-½, 2901.

10. The department must establish vision and hearing programs for children. It may delegate responsibility to other agencies or local bodies. ch. 23, 2331 et. seq.

11. The department promotes information on health for the general public. ch. 127, SS. 17.

12. The department licenses and sets standards for alcoholic treatment centers. ch. 111-½, 2301 et. seq.

The following act relating to prevention of developmental disabilities is a declared policy of the State of Illinois.

Prevention of Developmental Disability

An Act relating to the prevention of developmental disabilities. P.O. 78-557, eff. Oct. 1, 1973.

2101 Policy declaration. 1. It is hereby declared to be the policy of the State of Illinois that the prevention of perinatal mortality and conditions leading to developmental disabilities and other handicapping disabilities is a high priority for attention. Efforts to reduce the incidence of

perinatal risk factors by early identification and management of the high risk woman of childbearing age, fetus and newborn will not only decrease the predisposition to disability but will also prove to be a cost-effective endeavor, reducing State and private expenditures for the care and maintenance of those disabled from perinatal risk factors.

Finding:

I. There is no statewide coverage of public health departments on a county or multi-county basis. Therefore, an adequate level of health services is not evenly available throughout the state.

RECOMMENDATION

1. that the staff of the IL Department of Public Health and the Statewide Health Coordinating Council work with the citizens of counties to seek the passage of legislation which would require counties to provide public health services.

Illinois Department of Rehabilitation Services

The Department of Rehabilitation Services operates under the following statutes:

"An Act Creating a Department of Rehabilitation Services," June 26, 1979, P.A. 81-36, amending IL REV. STAT., ch. 23, §3430 et. seq.

"An Act in relation to State administration of institutions for the handicapped," August 13, 1979, amending IL REV. STAT. ch. 23, 3434 et. seq.

Section 3430 established Department of Rehabilitation Services (DORS) to provide for the rehabilitation of disabled persons. A disabled person is defined as any person who by reason of physical/or mental impairment is totally or partially incapacitated for independent living or gainful employment.

On July 1, 1979, certain programs serving handicapped individuals were transferred by the Governor's Executive Order No. 1 (1979), dated February 22, 1979, from the Department of Children and Family Services to the Department of Rehabilitation Services (formerly the Division of Vocational Rehabilitation [DVR]). These were the Illinois Visually Handicapped Institute, the Illinois Children's Hospital-School, the Illinois School for the Visually Impaired, the Illinois School for the Deaf, and Community Services for the Visually Handicapped.

Findings:

I. There are very limited services from the Department of Rehabilitation Services for mentally ill and emotionally disturbed minors, quantitatively and geographically.

II. Since 1960, the Department of Rehabilitation Services (formerly DVR) has had in force a cooperative work agreement with public school and/or joint agreement districts to

provide a Secondary Work Experience Program (SWEP). A number of the SWEP programs serve the school districts' programs for the emotionally disturbed.

The SWEP stands in the United States and in Illinois as a model program of cooperation between a state department and the local public school district.

III. There is a lack of sufficient vocational rehabilitation services for minors between the ages of 15 and 21 years who are able to be in local schools.

IV. Transition Program. In the fall of 1978 a program, entitled the Special Demonstration Project (SDP) was established at the Illinois School for the Deaf for the purpose of providing special programming for behaviorally disturbed adolescent hearing impaired students. The program ended in the summer of 1979 when the funding was cut.

Legislative support was gained and the program was again initiated the second semester of the 1979-80 school year.

The main objective of the program was to accept students who had the potential to learn at a normal rate, but because of behavior problems were unable to take advantage of other on-campus programs. After a short stay in the program, the plan was to transfer the students into either on-campus or community-based programs.

RECOMMENDATIONS

1. Expand the Secondary Work Experience Program so other children can benefit from the highly specialized program provided by DORS.

2. Improve linkages between the Illinois School for the Deaf, the School for the Visually Impaired and the Illinois Children's Hospital School and local education and community agencies.

3. Increase in-service training between DORS' staff and local education and community programs.

4. Continue to work in developing working relationships between DORS and other state and private agencies.

Illinois State Board of Education and Their Local Agent, the Public School District

The statutory authority is:

IL REV. STAT. 1977, ch. 122, §1 et. seq. "School Code"
IL REV. STAT. 1977, ch. 144, §36 et. seq. "Business and Vocational Schools Act."

The Education for all Handicapped Children Act, P.L. 94-142 should be included. The Illinois statutes should be read in concert with this federal law. The following is a summary of the requirements of P.L. 94-142.

. The law seeks to guarantee the availability of a free appropriate public education to all handicapped children ages 3 to 21.
. Each State must set forth in detail the policies and procedures to assure that all handicapped children residing in the state, regardless of the severity of their handicap, are identified, located and evaluated.
. Special education and related services must be made available at public expense, under public supervision and direction, and without charge.
. Policies and procedures must be in effect to protect the confidentiality of personally identifiable information.
. Individualized educational programs must be written for each child and must be reviewed at least once a year.
. Due process procedures must be guaranteed with respect to all matters of identification, evaluation, and placement.

Findings:

I. Article 14 of the Illinois School Code at the present time is more stringent than some of the provisions of Public Law 94-142.

II. Under P.L. 94-142 and state law, the state education agency is directed to develop agreements with other departments to serve the needs of emotionally disturbed children. These are in process in Illinois and have been strengthened with the Memorandum of Understanding of August 26 and 27, 1980. (See appendix I)

III. There are still a large number of out-of-state residential treatment facilities being used by IL school systems because of a dearth of appropriate facilities in Illinois.

IV. The concept of "least restrictive environment" set forth in P.L. 94-142 has sometimes been abused so that emotionally disturbed children are placed in settings which do not provide adequate support. The treatment needs of each child are peculiar to him; they cannot be determined by generalizations valid for many children but invalid for him.

V. P.L. 94-142 has forced on school districts a broad intake and evaluation responsibilities without adequate provision for necessary child welfare, medical and psychiatric consultation.

VI. A position step was taken in August 1980 when a Memorandum of Understanding* was reached between the Department of Public Aid, Department of Mental Health and Developmental Disabilities, Bureau of the Budget, Department of Children and Family Services, Department of Public Health, Illinois State Board of Education Department of Rehabilitation Services, and the Governor's Office. This Memorandum of Understanding sets in place a governmental interagency system.

*See Appendix I

RECOMMENDATIONS

1. that the outline in the Memorandum of Understanding be improved and strengthened.

2. that all interested citizens, all organizations concerned about children, and all agencies, state or private, be involved with the Illinois State Board of Education to define critical terms used in P.L. 94-142 such as: related services; least restrictive environment; appropriate, as it relates to educational service and placement for non-educational purposes.

Interdepartmental Finding:

I. There are united efforts for specific target groups but no state-wide coordinating mechanism between governmental agencies nor is there a state-wide mechanism to provide an avenue for resolving dilemmas when the minor's problems are multidimensional and they do not fit the eligibility criteria for any one agency.

a. The Governor's Youth Initiative represents one governmental effort in this direction for a limited number of minors under the jurisdiction of the Juvenile Court of Cook County. Expansion of the program is under way into four additional areas of the state: Champaign, East St. Louis, Peoria and Aurora. (See Appendix V from DCFS Human Services Plan Phase I: 1979-81 pages 141-143)

b. The Memorandum of Understanding of August, 1980 is an important and positive step toward the development of a coordinating system which would improve and strengthen the network of services for mentally ill and emotionally disturbed minors. The present system is based on the convenience of the fit. If the child does not fit the existing services, it is convenient for the agencies to deny service rather than to cooperate to the end that needs are adequately met.

RECOMMENDATIONS

1. that the Governor issue an Executive Order for the establishment of and funding of a system of coordination and follow-up services for mentally ill and emotionally disturbed children which would require the participation and cooperation of all state government agencies serving children throughout the state.
   A proposed model for an Interagency Cooperative program on a demonstration basis is in the appendix.

2. that consideration should be given to enactment of legislation which would formalize the mechanism established in the Governor's Youth Initiation Project.

3. Legislation should be enacted to create a Division for Mentally Ill and Emotionally Disturbed Minors within the Department of Mental Health and Developmental Disabilities.

Chapter 91½ - 100.2

The Director of Mental Health and Developmental Disabilities, herein referred to as Director, shall establish such subdivisions of the department of Mental Health and Developmental Disabilities in addition to those established under Sections 100-11 and 503 as shall be desirable and shall assign to the various subdivisions the responsibilities and duties placed upon the Department by the Laws of the State of Illinois.

Amend Chapter 91½ - Section 100.11

To maintain and operate a Division for Mentally Ill and Emotionally Disturbed Minors within the Department. The Division shall be headed by an Associate Director appointed by the Director with the consent of the Senate. The Associate Director shall be a qualified professional who has training and experience in clinical mental health services for minors or administration of treatment services for minors suffering from mental illness or emotional disturbance. Emotionally Disturbed minors are those youth whose feelings, reactions or behavior prevent or interfere substantially with normal growth and development. The Division shall have the following functions and responsibilities:

(a) ~~11~~ To maintain and operate the Institute for Juvenile Research. The Associate Director in consultation with the Director shall appoint a qualified person as superintendent of the Institute, and such other employees and assistants as may be necessary to conduct scientific studies, diagnose and promote the treatment of children who are delinquent, emotionally disturbed, mentally ill, mentally defective or socially maladjusted, or who are in danger of becoming so, to the end that delinquency, crime, mental disorders and other forms of human maladjustment may be prevented. The Institute shall make personal examination and social studies of such children in the custody or under the control of the Department or of any court, school, public or private social agency or parent or guardian.

(b) To provide essential services directly or indirectly by purchase of service, contracts, or grant-in-aid mechanisms to mentally ill or emotionally disturbed minors.

(c) In addition, the Associate Director shall be responsible for:

Case Finding, information and Referral Services - designed to identify minors in need of services; to locate needed services; to inform persons about services and their availability; and to assist minors to enter the service delivery system.

Staff Development Services - designed to assure the quality of required essential services by providing in-service training programs for staff.

Evaluation Services - designed to assess the quality and effectiveness of service delivery and to improve such delivery.

Consultation and Education Services - designed to provide or disseminate information and technical assistance aimed at increasing the knowledge and skills of persons who may have contact with minors in need of mental health services.

Consultation and inter-agency agreements - designed to provide other departments and service providers with technical assistance aimed at increasing the effectiveness of referrals to and from the Division of Mentally Ill and Emotionally Disturbed Minors, DMH/DD should institute a case management system to assure an appropriate individual services plan and appropriate designation of responsibility for mentally ill or emotionally disturbed minors who require the services of one or more additional agencies or departments.

Participation in pilot projects relating to a case coordination system pursuant to Section 100-16.2.

Administration of the program to assist families to place mentally ill children for whom no appropriate care is available in Department facilities, pursuant to Section 100 - 7.1.

Preparation of appropriation requests in separate line items for financing the operation of the Division of Mentally Ill and Emotionally Disturbed Minors and Section 100 - 7.1 on assistance to families placing mentally ill children. Consultation with Superintendents of Institutions and Regional Administrators of the department with respect to the preparation of appropriation requests for children and adolescent programs.

(d) The Associate Director of the Division of Mentally Ill and Emotionally Disturbed Minors shall be consulted in respect to the designation, alteration, or closure of any mental health facility for mentally ill or emotionally disturbed minors.

ARTICLE V. ADMISSION OF MINORS

3-500. Admission procedure-Restrictions

§ 3-500. A minor may be admitted to a mental health facility designated for minors for treatment of a mental illness or emotional disturbance only as provided in this Article or as provided in Section 3-10-5 of the Unified Code of Corrections, as now or hereafter amended.

3-501. Outpatient services-Consent-Costs

§ 3-501. (a) Any minor 14 years of age or older may request and receive counseling services or psychotherapy on an outpatient basis. The consent of his parent, guardian or person in loco parentis shall not be necessary to authorize outpatient counseling or psychotherapy. The minor's parent, guardian or person in loco parentis shall not be informed of such counseling or psychotherapy without the consent of the minor unless the facility director believes such disclosure is necessary. If the facility director intends to disclose the fact of counseling or psychotherapy, the minor shall be so informed. However, until the consent of the minor's parent, guardian or person in loco parentis has been obtained, outpatient counseling or psychotherapy shall be limited to not more than 5 sessions, a session lasting not more than 45 minutes.

(b) The minor's parent, guardian or person in loco parentis shall not be liable for the costs of outpatient counseling or psychotherapy which is received by the minor without the consent of the minor's parent, guardian or person in loco parentis.

3-502. Voluntary admission on minor's application - Notice to parents or guardian

§ 3-502. Any minor 16 years of age or older may be admitted to a mental health facility designated for minors as a voluntary patient under Article IV of this Chapter if the minor himself executes the application. A minor so admitted shall be treated as an adult under Article IV and shall be subject to all of the provisions of that Article. The minor's parent, guardian or person in loco parentis shall be immediately informed of the admission.

3-503. Admission on application of parent or guardian - Statement of psychiatrist or psychologist

§ 3-503. (a) Any minor may be admitted to a mental health facility designated for minors for inpatient treatment upon application to the facility director of the facility, if the facility director finds that the minor has a mental illness or emotional disturbance of such severity that hospitalization is necessary and that the minor is likely to benefit from inpatient treatment. Except in cases of admission under Section 3-504, prior to admission, a psychiatrist or clinical psychologist who has personally examined the minor shall state in writing that the minor meets the standard for admission. The statement shall set forth in detail the reasons for such conclusion and shall indicate what alternatives to hospitalization have been explored.

(b) The application may be executed by a parent or guardian or, in the absence of a parent or guardian, by a person in loco parentis. Application may be made for a minor who is a ward of the State by the Department of Children and Family Services or by the Department of Corrections.

Amended by P.A. 81-799, § 1, eff. Sept. 16, 1979.

3-504. Minors-Emergency admissions-Procedures

§ 3-504. (a) A minor who is eligible for admission under Section 3-503 and who is in such a condition that immediate hospitalization is necessary may be admitted upon the application of an interested person 18 years of age or older when, after diligent effort, the minor's parent, guardian or person in loco parentis cannot be located or refuses to consent to admission. Following admission of the minor, the facility director of the mental health facility designated for minors shall continue efforts to locate the minor's parent, guardian or person in loco parentis. If such person is located and consents in writing to the admission, the minor may continue to be hospitalized. However, upon notification of the admission, the parent, guardian or person in loco parentis may request the minor's discharge subject to the provisions of Section 3-508.

(b) A peace officer may take a minor into custody and transport the minor to a mental health facility designated for minors when, as a result of his personal observation, the peace officer has reasonable grounds to believe that the minor is eligible for admission under Section 3-503 and is in such condition that immediate hospitalization is necessary in order to protect the minor or others from physical harm. Upon arrival at the facility designated for minors, the peace officer shall complete an application under Section 3-503 and shall further include a detailed statement of the reason for the assertion that such immediate hospitalization is necessary, including a description of any acts or significant threats supporting the assertion, the time and place of the occurrence of such acts or threats, and the names, addresses and telephone numbers of other witnesses of such acts or threats.

(c) If no parent, guardian or person in loco parentis can be found within 3 days, excluding Saturdays, Sundays or holidays, after the admission of a minor, or if such person refuses either to consent to admission of the minor or to request his discharge, a petition shall be filed under the Juvenile Court Act to ensure that appropriate guardianship is provided.

(d) If, however, a court finds that it is necessary in order to complete an examination of a minor, the court may order that the minor be admitted to a mental health facility designated for minors pending examination and may order a peace officer or other person to transport the minor to such facility.

(e) Within 24 hours after admission under this Section, a psychiatrist or clinical psychologist who has personally examined the minor shall certify in writing that the minor meets the standard for admission. If no certificate is furnished, the minor shall be discharged forthwith.

Amended by P.A. 81-799, § 1, eff. Sept. 16, 1979.

Chapter 91½ - 3-200

ARTICLE II. GENERAL PROVISIONS

3-200. Admissions-Transfers by Department of Corrections-Release

§ 3-200. A person may be admitted as an inpatient to ~~a~~ an appropriate mental health facility for treatment of mental illness only as provided in this Chapter, except that a person may be transferred by the Department of Corrections pursuant to the Unified Code of Corrections, as now or hereafter amended. A person transferred by the Department of Corrections in this manner may be released only as provided in the Unified Code of Corrections, as now or hereafter amended.

(NOTE - Since this Section applies to adults as well as children, the use is made of "an appropriate" instead of "designated for minors")

Chapter 38 - 1003-10-5

(NOTE - Since this Section applies to DD and drug addicted minors as well as mentally ill, the words "an appropriate" which is already found in the Statute, suffices for transfer to "minor designated" facility. Thus, the Unified Correction Code remains as is, which follows:)

1003-10-5. Transfers to the Department of Mental Health and Developmental Disabilities

§ 3-10-5. Transfers to the Department of Mental Health and Developmental Disabilities. (a) If a person committed to the Juvenile Division meets the standard for admission of a minor to a mental health facility or is suitable for admission to a developmental disability facility as these terms are used in the Mental Health and Developmental Disabilities Code [1] or an addict as that term is defined in Section 3.03 of the "Drug Addiction Act",[2] the Department may transfer such person to an appropriate State hospital or institution of the Department of Mental Health and Developmental Disabilities for a period not to exceed 6 months, if the person consents in writing to the transfer. The person shall be advised of his right not to consent, and if he does not consent, such transfer may be effected only by commitment under paragraph (e) of this Section.

(b) The parent, guardian or nearest relative and the attorney of record shall be advised of his right to object, and if objection is made, such transfer may be effected only by commitment under paragraph (e) of this Section. Notice of the tranafer shall be mailed to the person's parent, guardian or nearest relative marked for delivery to addressee only at his last known address by certified mail with return receipt requested together with written notification of the manner and time within which he may object thereto. Objection to the transfer must be made by the parent, guardian or nearest relative within 15 days of receipt of the notification of transfer, by written notice of such objection to the Assistant Director or chief administrative officer of the institution or facility of the Department wherein the person was confined.

(c) If a person committed to the Department under the Juvenile Court Act [3] is committed to a hospital or facility of the Department of Mental Health and Developmental Disabilities under this Section, the Assistant Director of the Juvenile Division shall so notify the committing juvenile court.

(d) Nothing in this Section shall limit the right of the Assistant Director of the Juvenile Division or the chief administrative officer of any institution or facility to utilize the emergency admission provisions of the Mental Health and Developmental Disabilities Code [4] with respect to any person in his custody or care. The transfer of a person to an institution or facility of the Department of Mental Health and Developmental Disabilities under paragraph (a) of this Section does not discharge the person from the control of the Department.

(e) If the person does not consent to his transfer to the Department of Mental Health and Developmental Disabilities or if a person objects under paragraph (b) of this Section, or if the Department of Mental Health and Developmental Disabilities determines that a transferred person requires admission to the Department of Mental Health and Developmental Disabilities for more than 6 months for any reason, the Assistant Director of the Juvenile Division shall file a petition in the circuit court of the county in which the institution or facility is located requesting admission of such person to the Department of Mental Health and Developmental Disabilities. A certificate of a clinical psychologist or psychiatrist, or, if admission to a developmental disability facility is sought, of a physician that the person is in need of commitment to the Department of Mental Health and Developmental Disabilities for treatment or rehabilitation shall be attached to the petition. Copies of the petition shall be furnished to the named person, his parent, or guardian or nearest relative, the committing court, and to the state's attorneys of the county in which the institution or facility of the Juvenile Division from which the person was transferred is located, and the county from which the named person was committed to the Department of Corrections.

(f) The court shall set a date for a hearing on the petition within the time limit set forth in the Mental Health and Developmental Disabilities Code. The hearing shall be conducted in the manner prescribed by the Mental Health and Developmental Disabilities Code. If the person is found to be in need of commitment to the Department of Mental Health and Developmental Disabilities for treatment or rehabilitation, the court may commit him to that Department.

(g) In the event that a person committed to the Department under Section 5-10 of the Juvenile Court Act [4] is committed to facilities of the Department of Mental Health and Developmental Disabilities under paragraph (e) of this Section, the Assistant Director shall petition the committing juvenile court for an order terminating the Assistant Director's custody.

Amended by P.A. 81-337, § 5, *eff.* Aug. 31, 1979.

[1] Chapter 91½, ¶ 1-100 et seq.
[2] Chapter 91½, ¶ 120.3-8
[3] Chapter 37, ¶ 701-1 et seq.
[4] Chapter 37, ¶ 705-10

1003-10-6. Return and release from Department of Mental Health and Developmental Disabilities

§ 3-10-6. Return and Release from Department of Mental Health and Developmental Disabilities. (a) The Department of Mental Health and Developmental Disabilities shall return to the Juvenile Division any person committed to a facility of the Department under paragraph (a) of Section 3-10-5 [1] when the person no longer meets the standard for admission of a minor to a mental health facility, is suitable for administrative admission to a developmental disability facility, or requires hospitalization for drug addiction.

(b) If a person returned to the Juvenile Division under paragraph (a) of this Section has not had a parole hearing within the preceding 6 months, he shall have a parole hearing within 45 days after his return.

(c) The Juvenile Division shall notify the Director of the Department of Mental Health and Developmental Disabilities of the expiration of the commitment or sentence of any person transferred to the Department of Mental Health and Developmental Disabilities under Section 3-10-5. If the Department of Mental Health and Developmental Disabilities determines that such person transferred under paragraph (a) of Section 3-10-5 requires further hospitalization, it shall file a petition for commitment of such person under the Mental Health and Developmental Disabilities Code.[2]

(d) The Department of Mental Health and Developmental Disabilities shall release under the Mental Health and Developmental Disabilities Code, any person transferred to it pursuant to paragraph (c) of Section 3-10-5, whose sentence has expired and whom it deems no longer meets the standard for admission of a minor to a mental health facility, is suitable for administrative admission to a developmental disability facility, or requires hospitalization for addiction. A person committed to the Department of Corrections under the Juvenile Court Act [3] and transferred to the Department of Mental Health and Developmental Disabilities under paragraph (c) of Section 3-10-5 shall be released to the committing juvenile court when the Department of Mental Health and Developmental Disabilities determines that he no longer requires hospitalization for treatment.

Amended by P.A. 81-337, § 5, *eff.* Aug. 31, 1979.

[1] Paragraph 1003-10-5 of this chapter.
[2] Chapter 91½, ¶ 1-100 et seq.
[3] Chapter 37, ¶ 701-1 et seq.

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CHAPTER V

PLANNING FOR A CONTINUUM OF SERVICES

Background

Any master plan for emotionally disturbed children and adolescents must include a continuum of services. A continuum is a set of interlocking services designed to support and treat a range of children from those leading a relatively normal life in home and community to those who must live in a highly restrictive and protective environment. For emotionally disturbed children to be served adequately, services must be available in all local communities. These must be supplemented by more specialized programs provided on regional, state and even national levels. (See appendix VI for Compilation of Services)

In developing and maintaining this continuum of services one must be guided by a number of general principles:

1. Basic to a continuum of services for emotionally disturbed children is an adequate care-taking and educational system for serving all children. Implicit in this principle is concern for the unusual and deviant child as well as his more conforming classmate, and concern for the high risk infant as well as his more stalwart nursery mate.

2. All developmental levels from conception through the age of 21 must be taken into account in designing a continuum of services for emotionally disturbed children. Of particular importance is the recognition of uneven maturation and its effect on learning and adaptation.

3. The needs of the child must be viewed as central, but the continuum of services must be organized to support the family or surrogate in carrying out the responsiblity of child rearing. The family and family surrogates must be recognized as having the basic responsibility.

4. Medical, educational, psychological, social and other essential specialized services must be supportive of and easily accessible to those who are immediately responsible for the emotionally disturbed child and to the child himself.

5. The authority and responsibility for providing a continuum of services for emotionally disturbed children should be vested in a minimal number of agencies located as near as possible to the point of service delivery. On the other hand, it must be recognized that children at risk need multiple services.

6. The ultimate responsibility for seeing that a continuum of services is available rests with the public sector. However, the private sector should be encouraged to provide alternative and experimental programs for emotionally disturbed children, in order to test the validity of what is being offered through the public sector.

7. The continuum of services must be designed so as to provide well articulated programs which provide maximum support for the child, always with a view toward as much self-sufficiency as possible. Vigilance must ensure placement in a situation which fosters success for the child.

OVERVIEW OF THE CONTINUUM

In order to understand the continuum concept one must understand it in relationship to the individual child and his changing needs. Central to the process are the case finder and the case enabler. The case finder starts the process as he recognizes the child and his needs; the case enabler catalyzes the process by insisting upon proper and effective programming and placement. Case finding can occur at any stage of need. The case finder is the person who first points out the presence of the problem in the child. The child may be called to his attention or he may use such finding as the SAD indicators (See Chapter II). The case finder registers for the continuum that fact that there is indeed a case which needs its place on the continuum of services. He will activate the referral by urging the child and his family to seek needed services.

In the Study on Early location and Care of Children with Handicapping Conditions,* the Commission on Children recommended the establishment of case management teams. Central to the evaluation of emotionally disturbed children is such a team. In addition to the case management team, there must be a case enabler, whose administrative task it becomes to activate the steps of cooperative programming and re-evaluation of the child's needs, progress and programming. It is the task of the enabler to move the case along, to ensure proper attention to the changing needs of the child, to coordinate and integrate the observations and insights of the various professionals involved, and most importantly to remove the obstacles which block effective programs. In order to carry out this task the case enabler must depend upon the observations and clinical expertise of his team of colleagues but at the same time he retains the responsibility for ensuring proper attention to the changing needs of the child. The consolidation of clinical impressions and recommendations is crucial to the success of programming for children at risk and the case enabler's role is vital to its ongoing success.

The case enabler must be clearly specified for the team and to the child and his family. At times there may be reason to shift the responsibility for that activity from one professional to another, but at all times the person so designated must be clearly defined as the primary consultant, and his role must be observed.

The continuum of services is viewed as consisting of five segments between and among which it is essential that there be effective communication and calculated overlap. Viewed as independent steps in the continuum they must become a freely flowing path along which the troubled child moves in our efforts to find him a place in the community.

*Illinois Commission on Children: Report of a Committee on Early Location and Care of Children with Handicapping Conditions. January, 1972, pages 17-28.

a. Prevention and Case Finding

The emphasis on prevention is to detect potential cases early, before, in fact, children have become emotionally disturbed. Prevention has as its aim the deflection of high risk children into supportive programs which will be preventive rather than therapeutic.

b. Request for Service and Referral

At the moment that the child, his parent, or an interested case finder applies for service it is imperative that the recipient of that request, the intake worker, be knowledgeable about community services. The findings of Chapter III are crucial for understanding the workings of this portion of the continuum. At the moment of the request the intake worker must screen the need, and accept or refer. Refined referral to other agencies is a special skill developed only after years of experience and is based upon detailed and current knowledge of community resources. On the other hand, there is evidence that immediate contact with the agency to whom the child applies is often crucial. Even a few contacts with the child and his family may clarify the need. Often the family who can apply for help can program for itself or its members, if in the process of application, family members are able to delineate their focal needs and clarify their potential for action in their own behalf.

c. Diagnostic Evaluation and Program Planning

The diagnostic evaluation of emotionally disturbed children starts at the time of case finding. Its form varies with the professionals involved. Not all emotionally disturbed children need psychiatric evaluation as part of the initial diagnostic evaluation. The diagnostic process is itself a continuum moving from educational evaluation, to psychological testing, to medical evaluations, to laboratory studies, to psychiatric evaluation to vocational testing and to proper collation of the results of each and all.

d. Coordinated Placement, Educational and Therapeutic Services

Placement is the process of answering the questions: where, how and with what tools? One must first define the needs and then clarify the placement.

e. Long Range Planning and Follow-up

The continuum of services' concept carries with it the expectation that the child will use the depth and breadth of services needed, with the expectation that in time he will join the customary school and personal programs. The goal of special programming is its own extinction. However, for a selected few, such a goal is unattainable.

Findings:

I. The concept of a continuum of services is not characteristic of State or community programs in Illinois. There is no plan for such a continuum. Increasingly, the code agencies and the schools have become aware of children not well served by existing agencies and programs, yet efforts to serve these children have not included the concept of a continuum of service.

II. The Code agencies have delineated diagnostic groups of children for whom they will be responsible. Such policies have led to the underserving of children who do not fit into the designated categories as, for example, the mentally ill or a child who is primarily acting out his depression.

III. The specific impact of maturational factors in the development of emotional disturbance is often overlooked. One reflection of this is the limited services available for the diagnostic evaluation of children under 12 in hospital settings.

IV. Early detection and focal intervention of incipient emotional disorders are rarely available. Screening programs for small children from 0 to 3 are a welcome variant.

V. All too often the diagnostic process is focused on proving that a child is not eligible for services rather than on clarifying need and developing the necessary program. Especially for multiply handicapped children, programs are rarely suitable.

VI. The Department of Mental Health and Developmental Disabilities has no statement in its legal mandate delineating a responsibility for children and adolescents. In addition they have limited the services which they have developed for the mentally ill. (See Legal Mandates, Chapter IV)

VII. Department of Mental Health and Developmental Disabilities and the Department of Public Health have no line items for children's services.

VIII. The Department of Mental Health and Developmental Disabilities has given no priority to children's services in their grant-in-aid clinics nor is there any consistent statewide agreement as to the method of payment for out-patient services for wards of the state.

IX. The number of residential facilities for emotionally disturbed children who have delinquent and behavioral symptoms is limited and inadequate in Illinois. Programs for the most difficult children are not usually provided by interagency agreements. Often out-patient facilities necessarily assume responsibility for these children through default.

X. The concept of "least restrictive environment" as set forth in P.L. 94-142 is being misused, in ways which often programs for failure rather than for success.

XI. The study on residential facilities has been completed by the IL State Advisory Council on the Education of Handicapped Children but has not been implemented. It states current need for additional residential facilities for severely disabled children and adolescents and recommends that the State Board of Education suggest to the Legislature programs for serving these youth within Illinois.

Specific Findings:

I. Prevention and Case Finding

a. Failure to thrive is viewed as a pediatric illness with emotional components. Rarely is the symptom failure to learn viewed as a psychiatric and developmental condition.
b. Departments of Neonatology do not have appropriate linkage to child development specialists, for proper follow-up and continuing evaluation of high risk infants.
c. Mother-infant screening programs are available for children up to 18 months albeit somewhat unevenly throughout the state. There is no comparable coverage for children between 18 months and 3 years.
d. The school's responsibility for evaluation of children 3 to 5 is unevenly expedited through the state. There are growing programs for children under 3 but there is no systematic plan for further evaluation.
e. School health examinations and immunizations are required for school admission yet, even with such requirements in some communities children are discriminated against because of lack of free resources.

II. Request for Service and Referral

a. No community plan for intake and referral exists in most communities.
b. Liaison among schools and mental health professionals varies tremendously among communities; even when existent, the relationship is rarely collegial.
c. The intake function is often not valued within existing agencies. It is often assigned to the least experienced workers rather than to the most experienced, as is justified by its importance.
d. P.L. 94-142 has forced on school districts a broad intake and evaluation responsibility without adequate provision for necessary child welfare, medical and psychiatric consultation.
e. Community and professional awareness of available resources is limited. Unmet needs and duplication of services are not adequately clarified.

III. Diagnostic Evaluation and Program Planning

a. Adequate, in-depth evaluations of children and adolescents with emotional disturbances are unavailable in many areas of the state. Highly trained personnel are clustered in the urban areas.
b. Diagnostic nomenclature often reflects symptoms rather than the specific needs of the child. Rarely are intrapsychic factors delineated.
c. Consideration of a screening diagnostic study with clarification of the necessary in-depth study is rarely a part of the continuum. Adequate clarification of diagnostic needs with limitation of testing and other evaluations should lead to desired savings.
d. Duplication of diagnostic studies needs to be avoided.

IV. Coordinated Placement, Educational and Therapeutic Services

a. Case enablers are rarely designated across separate agencies and charged with appropriate ongoing responsibility.
b. The concept of the therapeutic environment is rarely central to programs. Too often the focus is exclusively on academic mastery rather than also on the emotional development of the child and the mastery of his skills as a contribution to his sense of self.
c. Cooperative communication with the goal of proper placement of an individual child has been lacking among the code agencies. The Memorandum of Understanding of August 26 and 27, 1980 is a positive step which will facilitate and strengthen this area. (See Chapter IV and Appendix I)

V. Long-range Planning and Follow-up

a. Rarely does a case enabler retain a sense of responsibility for children placed in institutions. The step of shifting the designated person is rarely enacted.
b. The conscious step of planning for long-term programs is often overlooked. Many emotionally disturbed children bounce from one facility to another rather than being assigned for the appropriate long-range period to a stable placement.

RECOMMENDATIONS

1. that a continuum be planned which provides a flow, a stream of service which focuses on the need of the individual child as he grows and his situation changes. The continuum permits programming based upon the dynamic changes in the child's and family life, as well as upon his inner capacities, deficiencies and conflicts and is in contrast to the concept of continuum often proposed which divides services into three major categories:

. Direct services - available to the emotionally disturbed children;
. Universal services - available to all children;
. Enabling services - integrating and coordinating services.

2. that children at risk be linked to evaluative services for the purpose of prevention that unwed mothers, high-risk infants, abused and neglected youngsters be viewed as potentially disturbed children and referred to appropriate services for evaluation and programming as indicated, and that Public Health Services be expanded to provide adequate prenatal care for mothers of all ages and all background regardless of financial eligibility.

3. that guided by the knowledge that stress is often an opportunity for growth as well as a potential for illness, every effort be made to offer supportive educational services for children and parents. Education for parents, orientation for all couples, in-service programs for teachers, all form a bulwark of prevention against the tide of the forthcoming wave of emotionally disturbed children.

4. that serious illness, death in the family, suicide and antisocial acting out be seen as opportunities for intervention in behalf of the survivors. That programs be offered in the schools on sexual development, and on the use of drugs, as well as on the principles of physical and psychological health.

5. that there be recognition of continuing need in each community for "central intake." In many communities it has become the task of the school pupil personnel services staff to perform this function. In other communities the local mental health clinic or the family service agency is seen as the appropriate agency for application and referral.

6. that diagnostic evaluation begin with case finding and continue throughout the process of the entire continuum, even to the point of placement at the far end of the continuum.

   Central to this process is consideration of the individual child who has problems, rather than the problems themselves. Clarification of the deficiencies or the conflicts is important but evaluation of the child's coping skills and other potential is as crucial.

7. that there be appropriate guidelines developed for selective screening and diagnostic evaluations which are adequate for purposes of programming and choice of indicated placement. Initial diagnostic screening should be seen as the first step in which diagnostic needs are clarified not as a complete diagnostic evaluation on which treatment is based.

8. that preferably placement be within the child's family and the local school and that programming address itself to the educational and emotional needs of the child with appropriate involvement of the family.

9. that if placement in a highly restrictive small group is indicated, with a need for psychotherapeutic and special educational intervention that placement be within a school setting and in a living situation which offers the greatest opportunity for the child's individual intellectual, social, and emotional development.

10. that appropriate placement be undergirded by the needed educational and therapeutic services, recognizing that whatever services are beneficial are therapeutic including primarily educational services and milieu support.

11. that the needed components of placement, education programming and psychotherapeutic interventions based on individual diagnosis be delineated for each child.

12. that all variations of therapeutic programs which are part of the continuum be based on proven child development principles and thorough knowledge of child welfare.

13. that in the broad range of treatment modalities, there be a selective focus for intervention. For some children with reactive disorders the treatment of choice may be to change a harmful situation. For others with abusing parents, family intervention or even placement in a protective setting may be necessary. For psychotic children hospitalization and medication, with continuing diagnostic clarification, may be the immediate need. With the proper allocation of resources and a stringent focus on selective placement, definitive programs can be developed throughout the state.

14. that the Department of Mental Health and Developmental Disabilities make a commitment to services for children and adolescents a priority, urging grant-in-aid clinics to make a similar commitment.

15. that State Board of Education assume responsibility for clarifying, in a single publication, each agency's procedures for application and appeals as well as criteria for acceptance into the program.

16. that clinics and private practitioners be urged to develop operating agreements with schools to enhance the efforts of the schools in behalf of emotionally disturbed children. The State Board of Education and Department of Mental Health and Developmental Disabilities should develop the guidelines.

17. that the Department of Public Health take responsibility for coordinating programs for high risk infants througnout the state, in addition to the ten centers now in operation.

18. that DMH/DD develop guidelines for the use of limited diagnostic evaluations as they relate to specific clinical conditions.

19. that DMH/DD take a leadership role in helping local agencies develop in-service training programs in single and coordinated agencies.

20. that research grants be made available through DMH/DD for the study of treatment failures as well as treatment successes with a view toward the refinement of programs, placements and therapy.

21. that the DMH/DD support a study of the needs of the multiply handicapped and seriously mentally ill children currently not being well served by the professions.

CHAPTER VI

ROLES AND RESPONSIBILITIES OF PUBLIC AND PRIVATE AGENCIES

Background

Need for services for emotionally disturbed children of all ages far exceeds the capabilities of programs that exist throughout Illinois. To fully meet needs agencies within both the public and private sectors must cooperate in planning, sharing resources, and offering services.

Development of a continuum of services in all regions of the state and including programs at all levels of intervention and intensity requires the knowledge, expertise, activities and resources of many individual agencies and the commitment of these agencies to work together and to complement one another.

While there appears to be general agreement that such a continuum is essential and that success and availability depends on full cooperation of public and private agencies, services on behalf of emotionally disturbed children are in short supply, often not available, and lacking in coordination between and among service programs. There appears to be no strong, concerted forward movement to bring about the comprehensive services needed.

Factors standing in the way of the desired objectives have been identified in this study and attention given, through the sending of two separate questionnaires to private voluntary agencies serving children and youth, to the ideas and suggestions of these leaders of the private sector. A summary of those responses is included in the appendix.

Findings:

I. Services to emotionally disturbed children in Illinois are critically limited at this time and there appears to be no strong, concerted forward movement to develop comprehensive services. On the contrary, some services are being terminated or diminished.

II. There is no statewide, comprehensive plan agreed upon by both public and private agencies for meeting the needs of emotionally disturbed children.

a. There has been no agreement on the identification of these children, their number, characteristics, needs, or required therapies.
b. Priorities in types of services shift frequently, handicapping continuity and maintenance of services.
c. Funding considerations and programmatic needs are often in conflict.
d. Fluctuation in perceived roles and responsibilities of public and private agencies have obstructed comprehensive planning.
e. Issues recently raised about liabilities, legal considerations and consumer monitoring have introduced uncertainty about what services can be provided and under what conditions.

f. No structure exists for linkage between the state and private sectors on a statewide basis.
g. Promotion of de-institutionalization priorities has impacted on the maintenance and development of much needed, quality residential care programs and slowed down planning toward a full continuum of service.
h. The high cost of quality residential care for emotionally disturbed children has made its expansion and maintenance difficult.

III. The geographic size of Illinois as well as its regionalized interests complicate state-wide cooperative planning for comprehensive care.

IV. There is confusion as to the respective roles and responsibilities of public agencies in meeting the needs of emotionally disturbed children.

a. Although state human service agencies are given broad mandates they are not often given the financial resources to meet these responsibilities. Limits are also sometimes set by the Governor and the Bureau of the Budget.
b. The expectation of acceptance of all requests by the public agency can often not be efficiently expedited for lack of resources and may affect all of the service negatively.
c. Federal legislation which places greater responsibility on local school districts to develop programs for emotionally disturbed children, while it provides a welcome hope for increased service, has added to the confusion about respective roles of public agencies.
d. Each public department has different rules and regulations for relating to the private sector, thus adding to the confusion of private agencies attempting to work with more than one state agency.
e. No one state agency has full responsibility for child and family services; fragmentation of total services tends to limit availability.

V. There are major differences between the private sector and the public sector as to their respective responsibilities for service to emotionally disturbed children. The private agency can determine the extent and nature of its service program in contrast to the no-reject responsibility of the public agency.

a. With some exceptions, private agencies accept responsibility for needed and varied service programs excluding residential treatment and/or custodial care for severely disturbed children and youth.
b. Progress has been made in private agencies' collaboration with the Department of Children and Family Services and the Department of Mental Health/Developmental Disabilities in meeting the needs of emotionally disturbed children but further development has been hampered by inconsistent and inadequate funding and lack of assurance of continuity of funding for purchase of care by the public agencies.

c. Many private agencies, receptive to creating new programs for the severely disturbed child, lack capital funds and are inhibited by single year commitment of funds by state agencies.
d. Sudden changes in public agency leadership and policies create uncertainty in private agencies about their own program development.
e. Private agencies hesitate to devise "no decline" programs because of the need to plan for children on an individual basis. On the other hand, some private agencies believe all service programs can be provided in the private sector, with the public agency providing technical assistance and funding.
f. Greater unanimity and effectiveness in the private sector have been provided by some coalitions of private agencies such as the Group for Action Planning in Chicago.

VI. In general, inadequate coordination/networking exists in bringing public and private agencies into joint planning and in service delivery for emotionally disturbed children.

RECOMMENDATIONS

1. that the Governor clearly reiterate his interest and support for the development of a full range of services for Emotionally Disturbed Children (including troubled and difficult older youth) and for their families-with emphasis on collaboration of public and private sectors, and with a willingness to make available necessary funds and resources.

2. that the Governor declare a moratorium against the closing of any state facilities or programs for Emotionally Disturbed Children, or the reduction of any such program, until there is evidence that such needs are being met adequately within other facilities or programs.

3. that the Governor's Human Services Sub-Cabinet strengthen its commitment and efforts to eliminate unnecessary barriers and red-tape which prevent reasonable and efficient delivery of services.

4. that the State Administration, with the support of the Legislature and the private sector, take a positive, aggressive, challenging stance toward the development of new and better facilities and programs for the Emotionally Disturbed Child--and capitalize on the interest and expertise of citizens. parents, and professionals in bringing about exciting new programs within the state of Illinois.

5. that public and private agency leaders, with strong citizen support, work together to advise legislators on the need and importance of service, on the potential for regionalized continuums of services, on laws and funding essential to the effort. Interested legislators should be identified and be encouraged to promote full attention to the needs and problems, as well as to the answers and solutions.

6. that private agencies, and the coalitions which include and represent them, actively participate and exercise leadership wherever possible in the identification of need, of needed resources, and of cooperative planning efforts relative to the requirements of Emotionally Disturbed Children.

7. that United Way leadership, all organizations concerned with children and citizens who play key roles, should inform themselves fully on the requirements of Emotionally Disturbed Children and on the continuum of programs needed so that high priority and funding emphasis can be maintained.

8. that the Illinois Bureau of the Budget and Directors of Illinois human service departments be committed to full consideration of needed programs and their costs before applying budgetary restraints which inhibit necessary planning and program development. Adequate, realistic funding to achieve quality and continuity in programs must be projected.

9. that at the State level, and at each Regional level, the Directors of human service departments be responsible for developing a coordinating unit to bring together human service department leaders and private sector leaders in setting specific goals and objectives.

10. that assistance of knowledgeable legislators and attorneys be secured to improve and clarify legislation, directives, and guidelines so that needed programs and services for Emotionally Disturbed Children can be maintained and developed, protecting the rights and needs of Children--and also protecting the rights and interests of service providers.

11. that quality residential care (open and closed) be included and recognized as first-line services when that is the children's first order of need.

12. that the State Administration and Legislature, after examination and study, make necessary changes and modifications in the legal mandates covering each human service department, to insure that responsibility is properly placed for provision of services for Emotionally Disturbed Children and to insure that comprehensive services are available, with minimal red-tap, to children throughout Illinois.

13. that the State administration and Legislature recognize that "no decline" services are an appropriate responsibility of public agencies and that these must be provided adequately throughout the state.

14. that efforts by state agencies to encourage the development of service programs by private agencies be accelerated, that these efforts be accompanied by multi-year commitments in terms of planning and funding, that purchase of service systems (Including Individual Care Grants) be strengthened to utilize private resources effectively and that public funds be made available to assist private agencies with capital costs.

15. that DMH/DD sustain short-term, crisis related, in-patient programs as well as long-term in-patient programs for the seriously disturbed child, that such programs be maintained until they are adequately provided in the private sector.

16. that DCFS develop regional shelter care facilities, with diagnostic components, for those children who need them.

17. that procedures, forms, budgets, reporting systems, applications, etc., of all state agencies serving children be simplified and standardized, with an effort to link these to the United Way procedures to increase cooperation between departments and between the public and private agencies.

CHAPTER VII

THE PREPARATION OF PROFESSIONAL PERSONNEL

Background

To provide a continuum of services for emotionally disturbed children the services of a number of professions are required. It is essential that these professionals have a knowledge of and respect for what each specialty can contribute. They must also understand that for a continuum of services to be truly continuos their skills, competencies and efforts must, to a large extent, overlap. The areas of overlap need to be viewed in a framework of cooperation and collaboration rather than one of competition.

Professionals may be grouped into those who provide 1) educational services to children and adolescents, 2) clinical and/or specialized diagnostic and treatment services to children with special needs and/or handicapping conditions, i.e., physical, emotional, social, and 3) child care services, sometimes referred to as paraprofessionals. All personnel, regardless of their professional discipline, share responsibility for 1) providing a growth facilitating environment for all children, 2) detecting early signs of malfunction and/or emotional disturbance, and 3) establishing working relationships with each other which minimize fragmentation of the child and ensure a holistic approach to treatment. Often children with learning disabilities, mental retardation, and physical handicaps suffer secondary emotional problems as a result of their handicapping condition. Those whose primary responsibility it is to work with emotionally disturbed children in both clinical and educational contexts need specialized training which includes supervised contacts with a wide-range of emotionally disordered individuals and their families as well as didactic course work.

In view of the relatively new concept of continuum and the increased complexity of current mental health needs, agencies and training institutions are faced with a need to review academic and in-service training programs to make them consistent with new knowledge and new needs.

Finding:

I. State laws and job specifications, defining and regulating minimum training, are ambiguous and non-specific as are university requirements for the various specialized areas of training. This deficiency is being reinforced by Public Act 81-1118 which places responsibility for certification procedures for many school professionals, including special education teachers and school social workers, in the colleges and universities, rather than with the Teacher Certification Board as in the past.

II. Children with learning disabilities, mental retardation and physical handicaps often suffer secondary emotional problems and require help from professionals with specialized training.

RECOMMENDATIONS

1. that closer coordination be developed among training programs within a single discipline and between disciplines for effective service on interdisciplinary teams serving emotionally disturbed children.

2. that regular monitoring and periodic appraisal of professional development programs (pre-service and in-service) and of criteria for the certification of competency be required so that they prepare as well as possible for changing needs and conditions in the field, including emphasis on direct work with emotionally disturbed children.

3. that a battery of certifying instruments and research methods be developed to evaluate fairly the outcome of different modes of training as they affect the level of competence achieved by graduates.

4. that training be provided on two levels: an advanced, specialized level for qualified workers and an ongoing, in-service training level for staff development and that in both these programs training be based on an internally coherent knowledge based on clearly articulated technical skills.

5. that a task force be appointed by the Board of Higher Education to examine training programs for persons preparing to serve emotionally disturbed children; that the task force be comprised of representatives of training programs, certifying bodies and practitioners from the fields of psychology (including clinical and educational); special education (pupil personnel guidance); medicine (pediatrics, psychiatry), nursing (psychiatric and pediatric); social work; corrections and child care.

6. that the task force be given the following charges:

   - To determine the core skills and functions common to all professionals involved in work with emotionally disturbed children.
   - To evaluate current training programs to determine how realistically they address the needs, responsibilities and functions graduates will be expected to assume and discharge when they enter programs serving emotionally disturbed children and their families.
   - To propose specific ways in which the members of the various disciplines may collaborate to benefit of the child and minimize fragmentation of services.
   - To encourage college and university faculties to utilize the expertise of clinical and other direct service personnel to provide students with learning opportunities that integrate theory and practice and offer supervised direct practice experience with a wide-range of emotionally disturbed children in different settings and contexts.
   - To develop strategies for sensitizing all personnel working with children to the possibilities of preventing emotional disturbance and for assisting them to intervene on both preventive and therapeutic levels so that regular programs and special facilities can be engaged in truly collaborative relationships.

7. that the State Board of Education develop a system for coordinating funds used for in-service training of Personnel working with emotionally disturbed children with in-service training in the code departments.

8. that the Teacher Certification Board in collaboration with the State Board of Education and the State Board of Higher Education and the Task Forces of Universities on Special Education evaluate the present training and experience requirements for approval of teachers of the emotionally disturbed in light of changed conditions in the schools, recent legislative requirements and the diversified needs of present-day school populations.

9. that the Department of Personnel in collaboration with the Department of Education and Registration and the Teacher Certification Board take steps to reconcile its standards of qualification for persons working with emotionally disturbed children with the requirements of the two agencies.

CHAPTER VIII

EVALUATION, ACCOUNTABILITY, DISSEMINATION

Background

American industry has long identified the successful enterprise as the one which included: a) research and development programs; b) quality control of processes; and 3) analytical and evaluative modalities and techniques.

Unfortunately, Illinois government has been slow to adopt these private sector approaches to systems of human services. Such programs should have evaluative procedures to determine: 1) the progress of the individual receiving the services, and 2) the long-term effect of the program on the individual.

In this way, providers of human services (agency board members as well as staff leaders) could be held accountable by: 1) the persons receiving the service, 2) the persons responsible for providing the funds for the services, and 3) consumers and citizen interests.

Accountability is best measured by well-designed evaluation programs. The legislator can best meet the needs of his constituents if the results and the future directions for dispensing human services are developed for him through appropriate methods of evaluation. Without effective evaluation programs, legislators, citizens and consumers have little ability to determine the effectiveness of any program other than through the traditional administrative channels.

At all times but especially when fiscal responsibility is a critical fundamental issue at all levels, objective techniques for evaluation should enhance the chances of survival of those programs which are effectively meeting the needs of its special constituency, emotionally disturbed children.

Findings:

I. There are no clear, well-established policies for program evaluation, no standardization of data or terminology and no funding for such processes in the children's services at the federal/state/community level.

II. Data are collected on a departmental, agency or institutional level with minimal cross-over between and among departments.

III. There is a need for delineation of criteria for evaluation processes.

IV. There is a lack of trained, competent personnel to conduct evaluations of programs.

RECOMMENDATIONS

1. that the state of Illinois develop a uniform, integrated reporting system on which to base evaluation of emotionally disturbed children.

2. that program evaluation be mandated to assure that:

   a. the needs of emotionally disturbed children and their families are being met
   b. legislative requirements are adhered to
   c. information about service is exchanged
   d. the quality of programs is such as to meet professional standards for service to children in an effective and efficient manner
   e. that funding options are appropriately utilized

3. that program evaluation be structured to determine:

   a. to whom services are being given, to whom they are not, and why
   b. whether legislative requirements are being met
   c. the effectiveness and efficiency of each program
   d. outcome for each child referred to and served by the programs
   e. compatability of priorities set by the Departments with current knowledge and professional considerations
   f. those conditions which make it impossible or difficult to meet legislative requirements, serve certain groups of children and their families or meet professional standards effectively and efficiently (as contradictory statutes or regulations, insufficient funds, inadequate staff training, failures of coordination or cooperation between or with departments)
   g. needs for specific programs to be improved, augmented, combined with others, moved, cut back or eliminated.

4. that the findings from program evaluations be utilized:

   . To help the State, County, and Local Departments to assess and improve their operations in light of the above determinations.
   . To submit reports of evaluation to the Governor, the Commission on Children, the Legislature and to local citizens' groups as appropriate.
   . To recommend appropriate changes to the Governor, the Legislature and the Departments.

5. that evaluations be conducted by evaluators from outside and within the department being evaluated with the participation of knowledgeable staff members and other professionals who understand the problems and treatment of emotionally disturbed children.

6. that there be periodic review of the rules, regulations, licensing and accreditation procedures on which evaluation and accountability in each department are based.

7. that departments set aside at least 2 percent of each program budget to provide time and staff for ongoing and on site evaluations of departmental programs.

8. that children and adolescents who are wards of State Departments or are served by them be tracked to determine the service given and outcome for each child.

9. that residential and institutional programs institute prospective follow-up procedures when the child is admitted and tracked at six-month intervals, at discharge, and annually for five years post-discharge within the statutory provisions for individual/confidentiality and the rights of the individual.

CHAPTER IX

CONCLUSIONS

Certain findings appear in the subcommittee reports with striking frequency:

- A lack of uniformity of definitions of emotionally disturbed children in community programs serving such children and, in many instances, the lack of any definition at all.
- A lack of available data on which to base an assessment of the extent of the problem and, more critical, the absence of any structure for gathering, collating and disseminating data throughout the state.
- Disparate and inadequate funding, uncoordinated with programmatic needs.
- Lack of coordinated, inter-disciplinary training and lack of provision for monitoring the performance of para-professional and professional staff caring for emotionally disturbed children.
- Lack of policy or provisions for program evaluation on which accountability could be based.
- Lack of adequate clinical, educational and residential treatment facilities.
- Lack of specificity in the legal mandates for service to emotionally disturbed children in Code programs and lack of adequate budgetary provisions.
- Lack of coordination between community programs and state agencies serving emotionally disturbed children.
- Lack of clarity between the roles and responsibilities of public and private agencies and lack of structure to synchronize these agencies and programs.

In response to these findings which identified the same lacks in every context examined by the subcommittees, the following recommendations are being made. It became clear that no effective steps could be taken toward provision of adequate services until a structure existed to plan, coordinate, deliver and oversee services to emotionally disturbed children. To meet this need, the committee's major recommendations is for legislation that will create a separate Division for Mentally Ill and Emotionally Disturbed Minors within the Department of Mental Health/Developmental Disabilities, incorporating the Institute for Juvenile Research in this new Division, designating the Department of Mental Health/ Developmental Disabilities the lead agency for planning and coordinating mental health services for minors on a statewide basis with responsibility for insuring that other services are available as necessary. (For proposed legislation see Chapter IV)

Through this organizational change, other recommendations of the committee support the implementation of a continuum of service for emotionally disturbed children, permitting programming focused on the need of the individual child, preventive, educational and therapeutic. These are the supporting recommendations:

. A coordinated program of public education about the needs of emotionally disturbed children.

. Strengthened inter-agency agreements, clarifying roles and responsibilities.

. Development of a pilot program to determine the outcome for children served, with a tracking program for follow-up. The importance of continuity in planning service delivery and follow-up was recognized throughout the committee's recommendations.

. Provisions for funding adequate to provide needed services, program assessment and unmet needs.

MEMORANDUM OF UNDERSTANDING BETWEEN
the Department of Public Aid
Department of Mental Health/Developmental Disabilities,
Bureau of the Budget, Department of Children and Family Services,
Department of Public Health, Illinois State Board of Education,
Department of Rehabilitation Services, and the Governor's Office
AUGUST 26-27, 1980

Governor's Purchased Care Review Board

1. The members of the Governor's Purchased Care Review Board agree to revise Rule 3.21 and Rule 3.31 as attached upon their approval by the Department of Education at the next regularly scheduled meeting of the Board.

2. The Governor's Purchased Care Review Board agrees to apply kule 3.30 (b) to the costs included in Rule 3.21 (b) to determine what is a reasonable level for such costs, based on staff analysis and report.

3. The Governor's Purchased Care Review Board agrees to work for alterations of state statutes or rules which will define clearly the differences between educational and non-educational placements and provide for payment for special education rendered in non-educational placements.

State Board of Education

1. The State Board of Education agrees that for 1980-81 no new psychiatric hospitals will be approved and that its rule 8.04.1 will be revised to prohibit new placements in currently approved facilities. This does not imply that an extended care facility, group home or other long-term care facility operated by or in conjunction with a licensed psychiatric hospital could not be approved as a residential facility.

2. The State Board of Education agrees to change any rules necessary so that no non-public facility will be eligible to receive educational placements unless its program is approved by the State Board of Education and its costs are approved by the Governor's Purchased Care Review Board and the facility agrees to charge no more then the Governor's Purchased Care Review Board costs for any educational placement. It is understood that the change in rules will lead to a change in the state approved contract format used for Section 14-7.02 placements.

3. The State Board of Education may make payment in 1980-81 and as necessary thereafter in order to assure the Office of Special Education that all children now placed in Section 14-7.02 facilities which make charges in excess of the approved costs will receive a free appropriate public education until such time as those children can be placed in facilities which do not charge in excess of the approved costs. In order to do so it will be necessary to do a survey of districts and facilities with children in such placements regarding current

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parental payments and their purposes and develop a review/payment mechanism for assuring that costs as necessary (i.e., proposed new Rule 3.21A, B, C) are paid for children with signed contracts so placed, and monitor same.

4. The Superintendent agrees to provide written directives to local education agencies (LEA's) regarding the preparation and content of individual education programs (IEP's). The rules and regulations of the State Board of Education will be modified to reflect the written directives given to LEA's regarding IEP's. The State Board of Education agrees to utilize all existing mechanisms to enforce implementation of present rules and regulations relating to the development of IEP's.

5. The State Board of Education will develop a method of review for IEP's which recommend future placement in non-public residential facilities. This review will assess the appropriateness of the IEP's proposed placement based on the restrictiveness of the environment, the participation of other state agencies that the placement is made solely for educational reasons and other criteria as specified. The rules and regulations of the State Board of education will be altered to reflect the procedures developed for prior review of IEP's.

6. The State Board of Education will recognize that certain categories of children (ages 3-21) are placed in residential facilities for primarily non-educational reasons. These categories include: a) children placed for mental health or developmental disabilities purposes in residential mental health facilities pursuant to the Mental Health and Developmental Disabilities Code and the powers and duties of the Department of Mental Health and Developmental Disabilities; b) children involved in juvenile court proceedings (or in family situations likely to lead to such proceedings) which would lead to the involvement of the Department of Children and Family Services (DCFS); c) children who have actions pending in juvenile court seeking adjudication for MINS or delinquency or are already adjudicated; d) persons against whom criminal charges are pending or who have been convicted as adults; e) status offenders; and f) children requiring primarily medical care and treatment. When residential placement for a person who is a member of any of these categories is contemplated, the LEA will invite representatives of the appropriate state agency(s) to attend the multi-disciplinary staffing to provide technical assistance and a preliminary assessment of the eligibility of the student to services of that state agency. The State Board of Education will revise its Rule 9.15 and prepare and implement any other rules and regulations necessary to accomplish this agreement.

Governor's Office and Other State Agencies

1. The Governor's Office agrees to provide direction to the directors of appropriate state agencies to participate fully and completely in the multi-disciplinary staffings as requested by the State Board of Education and LEA;s to meet agreement #6 above.

2. The Department of Mental Health/Developmental Disabilities assures that responsible relative liability in present cooperative placements between LEA's and Department of Mental Health/Developmental Disabilities is not paid by the parent.

If administrative or regulatory changes are not sufficient to implement this agreement, statutory changes will be sought.

This agreement is made without prejudice to the contentions of the parties to this agreement and its provisions are binding in the light of approval of the plan and release of the funds by the U.S. Department of Education. However, its provisions are subject to recision unless all proceedings related to Public Law 94-142 and Section 504 initiated against the Governor's Purchased Care Review Board and the Illinois State Board of Education by the Office of Civil Rights are dismissed.

Date Adopted

September 17, 1980

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II

MONEY INCOME AND POVERTY STATUS IN 1975 OF FAMILIES AND PERSONS IN THE U.S. AND NORTH CENTRAL REGION (SPRING 1976 SURVEY OF INCOME AND EDUCATION) - SIE

(*Total Number Families Surveyed -- 2, 849,000)

I POPULATION: (Note - use projected population figures for all Illinois counties supplied by Bureau of the Budget)

II *INCOME:	under $5,999 annual	$6,000--$11,999	$12,000--$19,999
	366,000 families	583,000 families	911,000 families
III RACE:			
A. WHITE:	249,000 families	486,000 families	814,000 families
B. BLACK:	116,000 families	93,000 families	90,000 families
C. OTHER:	18,000 families	22,000 families	26,000 families
IV TYPE OF FAMILY:			
A. Husband/Wife Families:	178,000 families	446,000 families	798,000 families
B. Wife Working:	43,000 families	144,000 families	375,000 families
C. Wife Not Working:	135,000 families	303,000 families	422,000 families
D. Male Head, No Wife Present:	10,000 families	21,000 families	30,000 families
E. Female Head, No Husband Present:	178,000 families	115,000 families	83,000 families
F. Mean Size of Family:	3.4	3.2	3.4
V NUMBER OF RELATED CHILDREN UNDER 18 YEARS OLD:			
A. No Related Children:	153,000 families	288,000 families	389,000 families
B. 1 Child:	60,000 families	114,000 families	192,000 families
C. 2 Children:	68,000 families	89,000 families	169,000 families
D. 3 Children:	40,000 families	48,000 families	95,000 families
E. 4 or More Children	38,000 families	43,000 families	65,000 families
VI WORK EXPERIENCE IN 1975:			
Worked Full Time Job	103,000 families	358,000 families	779,000 families
Did Not Work	234,000 families	166,000 families	90,000 families

III

July 29, 1980

Ms. Donna Simonson, Exec. Dir.
3 W. Old State Capital Plaza
Springfield, IL 62701

Dear Ms. Simonson:

As we discussed in our telephone conversation yesterday, I am sending along the tabulations I have completed on the group home and institution data from the Illinois Department of Children and Family Services (IDCFS). This data refers to the location and capacity of all group homes and institutions licensed by the IDCFS and does not indicate the various populations served by these agencies, i.e., age, sex, geographic area, etc. If you need that kind of refinement of the data, it would mean an examination of each agency's program and area of service. Some of that is available in the Metropolitan Chicago Social Service Directory, a publication of Comprehensive Community Services, Inc., an affiliate of our agency, but as the title implies, it does not cover the State of Illinois.

I have also included a sample of a possible graphic for displaying the above information. Hopefully, when I have completed work on the special run made for your agency, by the Illinois Department of Mental Health, the data obtained can be added to the graphic.

I will be in contact with you after I return from my vacation which runs through the end of August.

Sincerely,

Delia Zemont
Research Analyst

DZ:pmp
Enclosure

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United Way
of Metropolitan
Chicago

72 West Adams Street
Chicago Illinois 60603
Phone (312) 263-1756

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United Way
of Metropolitan
Chicago

72 West Adams Street
Chicago Illinois 60603
Phone (312) 263 1756

December 1, 1980

Ms. Donna Simonson, Exec. Dir.
Illinois Commission on Children
3 West Old State Capital Plaza
Springfield, IL 62701

Dear Ms. Simonson:

As you know, I met with Ms. Margaret Schilling to discuss the possibility of including in your Comprehensive Plan for Emotionally Disturbed Children data drawn from reports of the Illinois Department of Mental Health and Developmental Disabilities (IDMHDD). At that meeting I outlined my efforts to develop IDMHDD data, which was sent to me by Ms. Sylvia Vedalakis, into a format comparable to that which I used in the informational tabulations and proposed graphics which I prepared from data supplied by the Illinois Department of Children and Family Services (IDCFS) and already sent by me to you. The IDMHDD data was intended to supplement IDCFS data and particularly to provide information on the availability of services for emotionally disturbed children in Illinois on a county by county basis. Below is a summary of what we discussed.

An analysis of the IDMHDD data shows that the following relevent information was available for each program supported by IDMHDD on a facility by facility basis:

Fiscal 1978

- Percent of clients mentally ill
- Percent of clients developmentally disabled
- Percent of clients aged 0-12 years and 13-17 years

Fiscal 1980

- Amount of Grant Award
- Number of clients to be served

As a first step I completed a preliminary analysis of the data available for facilities located in Region 1A of IDMH and produced the following estimates on a county by county basis:

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Ms. Donna Simonson, Exec. Dir. December 1, 1980
Illinois Commission on Children

- Number of clients under 18 years
- Number of clients 0 through 12 years
- Number of clients 13 through 17 years
- Number of clients mentally ill-all ages
- Number of clients developmentally disabled -all ages

However, it was not possible to identify the mentally ill and developmentally disabled clients by specific age group.

When I discussed these findings with Ms. Schilling we agreed that the level of specificity of the information did not warrant analysis of data for the remaining IDMHDD regions. We also agreed that with the present system of reporting used by IDMHDD it is not possible to obtain specific information on services to mentally ill and developmentally disabled children under 22 years of age.

I am returning to you under separate cover all the materials that I received from Ms. Vedalakis. If I can be of further assistance, please feel free to contact me.

Sincerely,

Delia Zemont
Research Analyst

DS:pmp

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ACTIVE CHILD CARE GROUP HOMES LICENSED BY ILLINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES BY COUNTY OF FACILITY LOCATIONS, JUNE 13, 1980

County

Adams

Chaddock Boys' School-Group Home, Quincy
Woodland Group Home, Quincy

Bureau

Regina Group Home of Cov. Children's Home and Family Services

Champaign

Cunningham Children's Home Girls Group Home, Urbana
Cunningham Children's Home Boy's Group Home, Urbana
Cunningham Children's Home Illinois Group Home, Urbana
Cunningham Children's Home, Inez Rose Group Home, Urbana
Cunningham Children's Home Laban Peck, Group Home, Urbana
Cunningham Children's Home S. English Group Home, Urbana
Cunningham Children's Home Trevett Group Home, Urbana
The Roundhouse, Champaign

Christian

Assumption Community Home, Assumption
Kemmerer Village Boys' Group Home, Assumption

Cook

Ashland Group Home-Lawrence Hall School, Chicago
Avers Group Home of Lawrence Hall, Chicago
Casa Central Group Home, Chicago
Chase Group Home, Chicago
Dover Group Home, Chicago
Glenwood Group Home, Chicago
Greenleaf Group Home, Chicago
Gunnison Group Home, Chicago
Institute Applied Behavioral and Psychological Research Group Home, Chicago
Irene Cummings Comm. Group Home of JCB, Chicago
Jarvis Group Home, Chicago
John Pugh & Matilda Price Group Home of JCB, Chicago
La Casita, Chicago
Lakewood Group Home, Chicago
Mary Lawrence Ch. Trans. Group Home for Girls JCB, Chicago
McCormick House, Chicago
South Shore Group Home, Chicago
Sullivan House Group Home
Susanne Schulze Family Home, Chicago
The Place, Chicago
Touhy Group Home, Chicago
Wellington Group Home, Chicago
Aunt Martha's (Youth Service Center, Inc.), Park Forest
Brewer House, Evanston
Palatine Group Home, Palatine
Shelter, Inc., Group Home, Arlington Heights

DuPage

Project Home, Downers Grove
Ray Graham Dev. Home for Children, W.C., West Chicago
Tag Emergency Shelter for Girls, Naperville

Jackson

Huber Boys' Home, Carbondale

Jefferson

Illini Children's Christian Home, Inc., Dixon

Kane

The Fox Hill Group Home, Aurora

Kankakee

Kankakee Transitional Center for Youth, Kankakee

Lake

Arden Shore Group Home, North Chicago
Becker House (Group Home), Waukegan
Seymour House Group Home, North Chicago

Livingston

Salem Children's Group Home No. 1, Flanagan
Salem Children's Group Home No. 2, Flanagan

McLean

Franklin House, Normal
Gridley House, Bloomington
Linden Street Group Home, Normal
Locust House, Bloomington
Marc Center Group Home, Western Ave., Bloomington
Taylor House, Bloomington
Washington House, Bloomington
303 Normal Ave. House, Normal

Macon

Webster-Cantrell Hall Group Home for Girls, Decatur
Webster-Cantrell Hall Group Home for Boys, Decatur

Macoupin

Macoupin County Attention Home, Gillespie

Peoria

Adolescent Group Home, Peoria
Children's Home Sommer House, Group Home - Girls, Peoria
The Children's Home - Group Home for Boys, Peoria

Sangamon

Boys Farm Foundation, Springfield

Stephenson

King's Daughters' Boys' Residence, Freeport
King's Daughters' Girls' Residence, Freeport
King's Daughters' Transitional Living, Freeport

Vermilion

The Youth Shelter, Danville

White

Otho Williams Cottage, Carmi
Verhines Farm Cottage of Bap. Ch. Home, Carmi

Whiteside

Lutheran Group Home, Sterling

Will

Sterling Group Home, Joliet

Williamson

Hoyleton Group Home, Marion
Hoyleton Group Home, Marion

Winnebago

Maguire Group Home, Rockford

Cook/DuPage

Ray Graham Assoc. Development Group Home, Bensenville

Cook/Kane

Park Row House Group Home, Elgin
Plum Street Group Home, Elgin
College House Group Home, Elgin
Highland Avenue Group Home, Elgin

ACTIVE CHILD CARE INSTITUTIONS LICENSED BY ILLINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES BY COUNTY OF FACILITY LOCATION, JUNE 13, 1980

County

Adams

Chaddock Boys' School, Quincy
Woodland Home for Orphans and Friendless, Quincy

Bureau

Covenant Children's Home and Family Services, Princeton

Champagin

Annabelle Huling Memorial Home, Rantoul
Illini Children's Christian Home, Inc., St. Joseph

Christian

Kemmerer Village, Assumption

Cook

Angel Guardian Child and Family Center, Chicago
Austin YMCA Transition Center, Chicago
Chapin Hall for Children, Chicago
Drake House, Chicago
Drake House - Clair Christian Center, Chicago
Drexel Place, Chicago
Garfield Park Outpost - Methodist Youth Services, Chicago
Grand Boulevard Outpost - Methodist Youth Services, Chicago
House of the Good Shepherd, Chicago
Institute for Developmental Learning, Chicago
Lawrence Hall School for Boys, Chicago
Lincoln Park Outpost - Methodist Youth Services, Chicago
Lydia Home Association, Chicago
Marcella Residence, Chicago
Maryville Academy, Virginia Residence, Chicago
Masai Village, Chicago
Mercy Mission, Chicago
Misericordia Home North, Chicago
New Life House, Chicago
New World Christian Ministries-Imani House, Chicago
Our Place - Programs Positive, Inc., Chicago
St. Leonard's House Cash-Inn, Chicago
St. Mary of Providence, Chicago
The Home of the South Side Christian Center, Chicago
The Place - Association House of Chicago, Chicago
Uhlich Children's Home, Chicago
Volunteers of America Living Center for Girls, Chicago
Wabash YMCA Transition Center, Chicago
Camelot Care Center, Inc., Palatine
Crisis Home, c/o Patten Cot., Park Ridge-Girls, Park Ridge
Edison Park Home, Park Ridge
Elim Christian School, Palos Heights

Evanston Children's Center of Cn & As of IL, Evanston
Glenwood School for Boys, Glenwood
Illinois Masonic Children's Home, LaGrange
Little City Training and Treatment Center, Palatine
Lt. Joseph P. Kennedy School for Exceptional Children, Palos Park
Maryville Academy, Des Plaines
Maryville Academy - Maywood House, Maywood
Park Ridge School for Girls, Park Ridge
Sadie Waterford Manor, Crestwood
The Cradle Society, Evanston
Westgate Respite Intervention Program, Oak Park

Crawford

Easter IL Christian Assembly Chns Chr Home, Oblong

DeKalb

DeKalb County Villages, DeKalb

DuPage

Lutherbrook Children's Center of LC & FS, Addison
Sunny Ridge Home for Children, Wheaton

Edgar

Edgar County Children's Home, Paris

Jefferson

United Methodist Children's Home, Mt. Vernon

Kane

Mooseheart, Mooseheart
New Life House for Boys, Aurora

Kankakee

Youth Opportunities Unlimited, Inc., Kankakee

Lake

Allendale School for Boys, Lake Villa
Applewood School, Wauconda
Arden Shore Association, Lake Bluff
Klingberg School, Mundelein
Glenkirk Home, Lake Forest

Lee

Nachusa Lutheran Home for Children, Nachusa

Livingston

Salem Children's Home, Flanagan

Logan

Odd Fellows Children's Home of Illinois, Lincoln

McDonough

Illinois Children's Christian Home, Macomb

McLean

Morgan Washington Home, Bloomington
The Baby Fold, Normal
Victory Hall Boys' Home-McLean County, Normal

Macon

Progress Resources Center - Woodford Home, Decatur
Webster-Cantrell Hall Mn. Res. Support UN, Decatur

Madison

Catholic Children's Home, Alton

Monroe

New Hope Living and Learning Center, Waterloo

Peoria

Florence Crittenton Home Crisis Nursery, Peoria
Guardian Angel Home, Peoria
Peoria Assoc. for Retarded Cit Respite Center, Peoria
South Side Mission of Peoria, Inc., Peoria
The Children's Home of Peoria, Peoria
Youth Farm, Inc., Peoria

Rock Island

Arrowhead Ranch, Coal Valley
Bethany Home, Moline
Bethany Home West, Rock Island

St. Clair

Alternative and Rehabilitation Living Center, East St. Louis
Children, Family & Youth Advocacy Council, Belleville
St. John Children's Home, Belleville

Stephenson

Norman C. Sleezer Juvenile Homes, Inc., Freeport
St. Vincent's Residential School, Freeport
St. Francis School for Exceptional Children, Freeport

Vermilion

Wheeler's Home - Farm School - Exceptional Children, Rankin

Washington

Hoyleton Children's Home, Hoyleton

White

Baptist Children's Home, Carmi

Whiteside

Illini Children's Christian Home, Erie

Will

Guardian Angle Home, Joliet

Winnebago

Forth Street Bridge, Rockford
Goldie B. Floberg Center for Children, Rockton
Roc Vale Teen Homes, Rockford
Roescrance Mem. Homes - Children and Boys, Rockford
Rosecrance Rural Campus, Durand
Seeds, Rockford

Cook/DuPage

Bartlett Learning Center, Bartlett

Cook/Kane

Larkin Home for Children, Elgin

Cook/Will

Child Development Center, Inc., Park Forest

Clinton/Marion

Hudelson Baptist Children's Home, Centralia

ACTIVE CHILD CARE FACILITIES LICENSED BY
ILLINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES
BY COUNTY OF FACILITY LOCATION
JUNE 13, 1980

Location	Licensed Facilities for Children Under 18 Years					
	Institution		Group Home		Total	
	Number	Capacity	Number	Capacity	Number	Capacity
STATE	104	4,268	82	590	186	4,858
Cook	43	1,791	26	204	69	1,995
(Chicago)	(28)	(803)	(22)	(173)	(50)	(976)
(Suburban Cook)	(15)	(988)	(4)	(31)	(19)	(1,019)
McLean	3	43	8	44	11	87
Champaign	2	38	8	61	10	99
Peoria	6	167	3	19	9	186
Lake	5	266	3	21	8	287
Winnebago	6	223	1	6	7	229
Stephenson	3	90	3	21	6	111
DuPage	2	58	3	18	5	76
Cook/Kane	1	13	4	26	5	39
Adams	2	73	2	12	4	85
Macon	2	30	2	18	4	48
Kane	2	661	1	8	3	669
Christian	1	46	2	12	3	58
Livingston	1	50	2	12	3	62
Rock Island	3	112			3	112
St. Clair	3	42			3	42
White	1	48	2	20	3	68
Bureau	1	36	1	7	2	43
Jefferson	1	26	1	10	2	36
Kankakee	1	8	1	8	2	16
Vermilion	1	24	1	8	2	32
Whiteside	1	12	1	8	2	20
Will	1	24	1	6	2	30
Williamson			2	16	2	16
Cook/DuPage	1	50	1	6	2	56
Crawford	1	12			1	12
DeKalb	1	8			1	8
Edgar	1	24			1	24
Jackson			1	8	1	8
Lee	1	40			1	40
Logan	1	24			1	24
McDonough	1	12			1	12
Macoupin			1	6	1	6
Madison	1	86			1	86
Monroe	1	52			1	52
Sangamon			1	5	1	5
Washington	1	30			1	30
Cook/Will	1	8			1	8
Clinton/Marion	1	41			1	41

ACTIVE CHILD CARE FACILITIES LICENSED BY
ILLINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES
BY COUNTY OF FACILITY LOCATION
JUNE 13, 1980

Location	Licensed Facilities for Children Under 18 Years					
	Institution		Group Home		Total	
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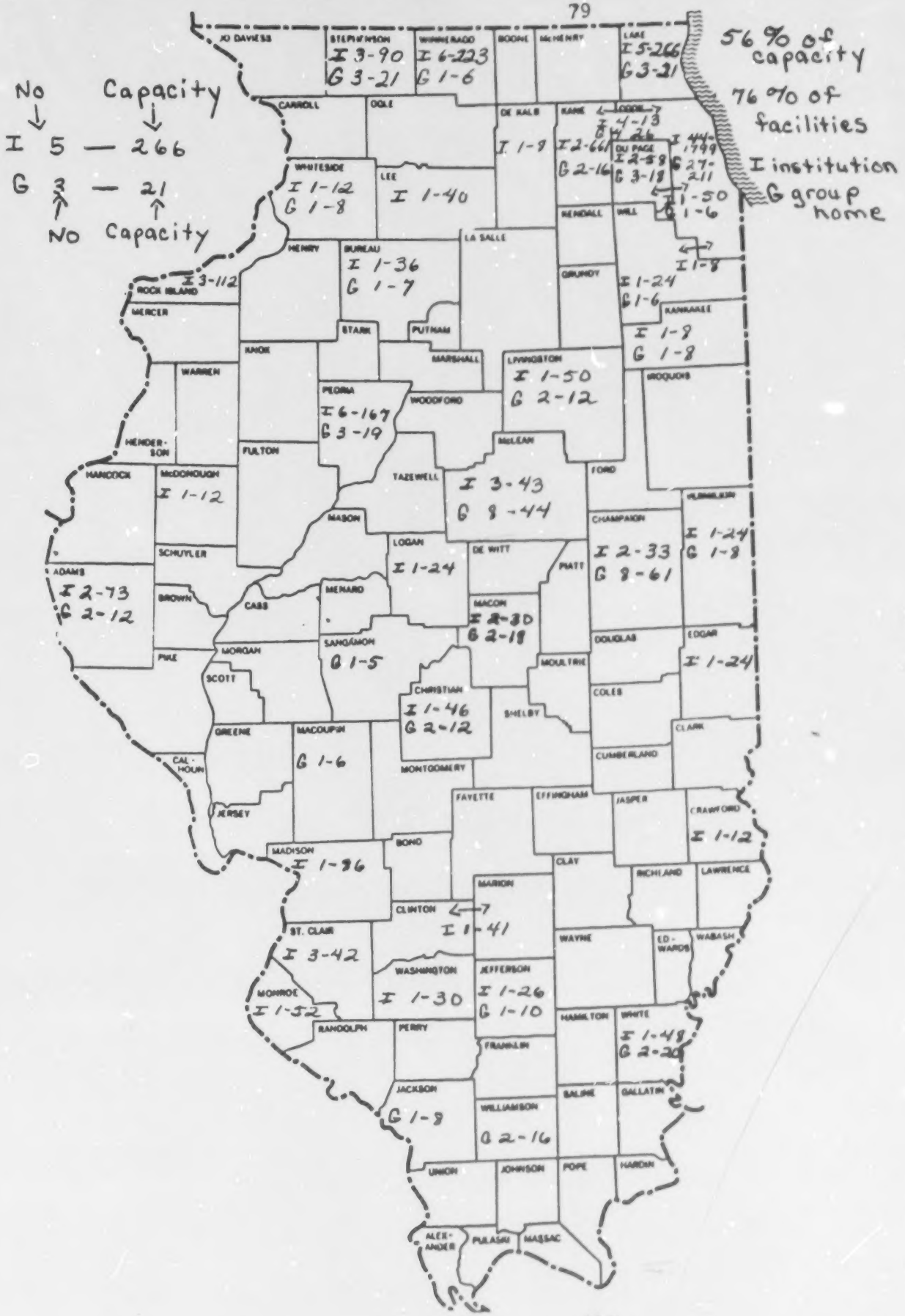
Cook	43	1,791	26	204	69	1,995
(Chicago)	(28)	(803)	(22)	(173)	(50)	(976)
(Suburban Cook)	(15)	(988)	(4)	(31)	(19)	(1,019)
Kane	2	661	1	8	3	669
Lake	5	266	3	21	8	287
Winnebago	6	223	1	6	7	229
Peoria	6	167	3	19	9	186
Rock Island	3	112			3	112
Stephenson	3	90	3	21	6	111
Champaign	2	38	8	61	10	99
McLean	3	43	8	44	11	87
Madison	1	86			1	86
Adams	2	73	2	12	4	85
DuPage	2	58	3	18	5	76
White	1	48	2	20	3	68
Livingston	1	50	2	12	3	62
Christian	1	46	2	12	3	58
Monroe	1	52			1	52
Macon	2	30	2	18	4	48
Bureau	1	36	1	7	2	43
St. Clair	3	42			3	42
Lee	1	40			1	40
Jefferson	1	26	1	10	2	36
Vermilion	1	24	1	8	2	32
Washington	1	30			1	30
Will	1	24	1	6	2	30
Edgar	1	24			1	24
Logan	1	24			1	24
Whiteside	1	12	1	8	2	20
Kankakee	1	8	1	8	2	16
Williamson			2	16	2	16
Crawford	1	12			1	12
McDonough	1	12			1	12
DeKalb	1	8			1	8
Jackson			1	8	1	8
Macoupin			1	6	1	6
Sangamon			1	5	1	5
Cook/DuPage	1	50	1	6	2	56
Cook/Kane	1	13	4	26	5	39
Cook/Will	1	8			1	8
Clinton/Marion	1	41			1	41


No ↓ Capacity ↓
I 5 — 266
G 3 — 21
↑ No ↑ Capacity
56% of capacity
76% of facilities
I institution
G group home
JO DAVIESS
STEPHENSON I 3-90 G 3-21
WINNEBAGO I 6-223 G 1-6
BOONE
McHENRY
LAKE I 5-266 G 3-21
CARROLL
OGLE
DE KALB I 1-9
KANE I 4-13 G 4-26 I 444-1799
DU PAGE I 2-58 G 3-19 G 27-211
I 2-66 G 2-16
WHITESIDE I 1-12 G 1-8
LEE I 1-40
I 1-50 G 1-6
KENDALL
WILL
I 1-8
HENRY
BUREAU I 1-36 G 1-7
LA SALLE
ROCK ISLAND I 3-112
GRUNDY I 1-24 G 1-6
MERCER
KANKAKEE I 1-9 G 1-8
STARK
PUTNAM
KNOX
MARSHALL
LIVINGSTON I 1-50 G 2-12
WARREN
IROQUOIS
PEORIA I 6-167 G 3-19
WOODFORD
HENDERSON
McLEAN I 3-43 G 8-44
FULTON
FORD
HANCOCK
McDONOUGH I 1-12
TAZEWELL
CHAMPAIGN I 2-33 G 8-61
VERMILION I 1-24 G 1-8
MASON
SCHUYLER
LOGAN I 1-24
DE WITT
PIATT
ADAMS I 2-73 G 2-12
BROWN
CASS
MENARD
MACON I 2-30 G 2-18
DOUGLAS
EDGAR I 1-24
SANGAMON G 1-5
PIKE
MORGAN
SCOTT
MOULTRIE
COLES
CHRISTIAN I 1-46 G 2-12
SHELBY
CLARK
GREENE
MACOUPIN G 1-6
CUMBERLAND
CALHOUN
MONTGOMERY
JERSEY
FAYETTE
EFFINGHAM
JASPER
CRAWFORD I 1-12
MADISON I 1-96
BOND
CLAY
RICHLAND
LAWRENCE
MARION
CLINTON I 7 I 1-41
ST. CLAIR I 3-42
WAYNE
EDWARDS
WABASH
WASHINGTON I 1-30
JEFFERSON I 1-26 G 1-10
MONROE I 1-52
HAMILTON
WHITE I 1-48 G 2-20
RANDOLPH
PERRY
FRANKLIN
JACKSON G 1-8
WILLIAMSON G 2-16
SALINE
GALLATIN
UNION
JOHNSON
POPE
HARDIN
ALEXANDER
PULASKI
MASSAC

Ms. Sylvia Vedalakis
Illinois Commission on Children
3 West Old State Plaza, Room 206
Springfield, IL 62701

Dear Ms. Vedalakis:

This letter is in response to your request for data in developing the Comprehensive Plan for Emotionally Disturbed Children prepared by your office. An earlier compilation provided a breakdown focusing on the number of mentally ill clients and the costs associated with those services served in various settings supported by the Department in Fiscal Year 1978 ranging in ages of 0 to 21 years.

This breakdown has been revised with the assistance of the Division of Information Services (DIS) to provide an unduplicated count of mentally ill clients and the costs of services ranging in ages of 0 through 21 years.

Presently standard Department reports record units of services from client events rather than actual number of clients. In addition, the standard reports display costs and units of service by age groupings (Children 0 to 13, Adolescent 13 to 18, Adult 18 to 65, and Elderly 65+). Modifications of these reports have been developed; however, our information system is limited in one area in that it does not have the capability to retrieve certain data outside the designated above-mentioned age grouping. In this case, the unretrievable data affects the age grouping from 18 through 21 years.

As a result, DIS has devised a factoring process to compensate for these "unretrievable clients"* whereby all cost and units of service totals can be multiplied by 1.09 to provide representative estimates for the age group from 18 through 21 years.

The following information should address the data needs you requested.

1) Number of children served by DMHDD ranging from 0 through 21 years of age in Fiscal Year 1978 in both state aided and state operated settings.

Problem Area	Clients Served 0 through 21 yrs.	Clients Served 0 through 21 yrs. (including estimate of unretrievable clients)
Mentally ill	27,721	30,216
Developmentally Disabled	17,587	19,170

Alcoholism	1,112	1,212
Other***	3,883	4,232
TOTAL	50,303	54,830

Total multiplied by factor of 1.09 = 54,830

2) Number of children served in institutional settings operated by DMHDD ranging from 0 through 21 years of age in Fiscal Year 1978.

Problem Area	Clients Served 0 through 21 yrs.	Clients Served 0 through 21 yrs. (including estimate of unretrievable clients)
Mentally Ill	1,490	1,624
Developmentally Disabled	2,527	2,754
Alcoholism	7	8
Other***	269	293
TOTAL	4,293	4,179

Total multiplied by factor of 1.09 = 4,679

3) Number of children served in DMHDD aided (grant-in-aid agencies) programs ranging from 0 through 21 years of age.

Problem Area	Clients Served 0 through 21 yrs.	Clients Served 0 through 21 yrs. (including estimate of unretrievable clients)
Mentally Ill	26,214	28,573
Developmentally Disabled	13,930	15,184
Alcoholism	1,105	1,204
Other***	3,614	3,939
TOTAL	44,863	48,900

Total multiplied by factor of 1.09 =48,900.

4) Number of children served in DMHDD aided (Purchase Care for Mentally Ill Children in Private Residential Facilities) programs ranging from 0 to 18 years of age in Fiscal Year 1978.

Number of Clients	DMHDD Cost
50 Clients	$623.4

5) Total DMHDD Costs in serving children ranging from 0 through 21 years of age in Fiscal Year 1978 in both state aided and state operated setting.

Ms. Vedalakis
April 18, 1979
Page Three

Problem Area	Total Cost 0 Through 21 Years	DMHDD Cost 0 through 21 yrs. (including estimate of unretrievable clients)	Total Cost 0 Through 21 Years	DMHDD Cost 0 through 21 yrs. (including estimate of unretrievable clients)
Mentally Ill	$26,010.3	$28,351.2	$34,936.9	$38,081.2
Developmentally Disabled	$54,420.8	59,318.7	71,992.6	78,471.9
Alcoholism	260.0	283.4	440.0	480.0
Other***	2,315.3	2,523.7	3,215.8	3,505.2
TOTAL	$83,006.3	$90,477.0	$110,585.3	$120,538.3

Total "DMHDD Cost" multiplied by factor of 1.09 = $90,477.0
Total "Total Cost" multiplied by factor of 1.09 = $120,538.3

Please Note:
* All of the above quoted costs are expressed in thousands of dollars.
** "Unretrievable Clients" are defined as all clients who received services as nonregistered clients or collaterals of registered clients.
*** Category "Other" includes "Drug" population.

I trust the above information should satisfactorily address your requested data needs. Please feel free to contact me if further information should be needed.

Sincerely,

Joyce Helander
Division of Community Services

JH/js

cc: Doug Spencer
Pat Barger

REPRODUCED BY IL COMMISSION ON CHILDREN

For Committee on Emotionally Disturbed Children

TO: AGENCIES AND ORGANIZATIONS SERVING EMOTIONALLY DISTURBED AND BEHAVIORALLY DISORDERED CHILDREN

FROM: ILLINOIS COMMISSION ON CHILDREN

RE: QUESTIONNAIRE - *SUMMARY OF REPLIES RECEIVED AS OF 2/18/79 (76 Questionnaires returned of total 160 mailed)*

Please answer the following questions and return this questionnaire to the Commission on Children by January 31, 1979.

1. Do you have a program designed to promote public awareness of the needs of emotionally disturbed and behaviorally disordered children?

Yes *41* No *35*

If yes, please describe the nature of this program.

35 respondents conduct either media campaigns through radio, TV, and newspapers or provide a speakers bureau or both. Four organizations provide inservice training or workshops. Only one organization mentioned developing a "community information bank."

2. Do you have a program designed to inform the public of existing services for emotionally disturbed and behaviorally disordered children?

Yes *47* No *27*

If yes, please describe nature of this program.

23 respondents include information on existing services as a regular part of their public awareness programs. Six organizations distribute information directly toward individual school children, business personnel, all school districts, etc. Nine indicate available services to clients during the referral process.

3. Do you have a program designed to influence legislation in the interest of emotionally disturbed and behaviorally disordered children?

Yes *16* No *57*

If yes, please describe the program.

Ten respondents rely on parent or affiliate organizations to monitor and attempt to influence legislation. Eight respondents assign a staff person to act as legislative monitors or liaison.

4. Does your organization provide direct services to emotionally disturbed and behaviorally disordered children?

Yes *61* No *13*

If yes, please describe.

18 respondents provide educational programs, some combined with treatment programs. 15 respondents used the term mental health services or treatment services to describe their programs. Of these 15, only 3 provide inpatient care. Other providers included counseling (9), health (3), outreach (1) recreation (5).

5. What do you view as the major problems and/or gaps in the network of services for emotionally disturbed and behaviorally disordered children? Please explain --

31 respondents mentioned lack of essential services and facilities available including clinical and educational; in-patient and out-patient; lack of support services, networking, short-term, long term alternatives. 18 respondents feel there is a need for a systems approach to planning, referral treatment and development of treatment models. These 18 referred to lack of cooperation between agencies, departments. Lack of fiscal resources and human resources (adequately trained) is also a problem. In conclusion, one notes an overriding consensus on one issue: gross inadequacies at all levels of care and a need for a systems approach to planning, funding and service delivery.

(Optional) SIGNED_____

AGENCY OR ORGANIZATION_____

Addressed envelope enclosed.

Submitted by Mrs. Barbara Malany

VI

INTER-AGENCY COOPERATIVE PROGRAM FOR EMOTIONALLY DISTURBED CHILDREN/ A DEMONSTRATION PROJECT

Introduction:

The need for coordination among mental health, social services and special educational services serving the emotionally disturbed population is clear in order to keep children from falling between the gaps in services.

Frequently this population needs a range of services within multiple service systems and may not receive needed services for a number of reasons. No one agency has primary responsibility to see that services are provided and accessible. There is no advocate role for this population from any segment of the provider groups and there is limited consumer advocacy.

Goal:

To create a more accessible and coordinated system of services for emotionally disturbed children and adolescents within a community.

Objectives:

1. To establish a statewide Steering Committee appointed by the Governor to oversee and monitor the Demonstration Project.
2. To designate a site for the Demonstration Project.
3. To design and test a model for inter-agency agreements that effectively organizes the state agencies into a coordinating unit: a) which facilitates the accessing of services based on determination of comprehensive needs; 2) which provide diagnostic and evaluation service; 3) which develop a plan for the individual child; 4) which includes the development and monitoring of an effective network of services.
4. To design and test the model related to the integration of the functions of: a) diagnosis/evaluation; b) service plan development; c) and case management.

Project Description:

The proposed demonstration project would be a cooperative arrangement among the Departments of Family & Children, Mental Health and Developmental Disabilities, State Board of Education, and other agencies as needed to establish a coordinating unit for utilization of the functions of: a) diagnosis and evaluation, b) service development, and c) case management.

This model would not require a totally new system to be developed. Rather it would be coordinating resources already in place, and attempting to bring rationality to a fragmented system of individual programs and personnel. The "targeted" population of emotionally disturbed children frequently requires a mix of health, social, educational services from many sectors of the community involving various professional skills. Providing limited services frequently does not meet the comprehensive psycho-social, physical, and educational needs of this population.

At the state level a task force would be appointed by the Governor, consisting of the Directors of the three major agencies: Department of Mental Health and Developmental Disabilities, Department of Children and Family Service, State Board of Education and other relevant agency heads. This State Committee would have overall responsibility for guiding the development of the Project.

This task force will have a general responsibility for selecting the site for the project and determining a lead agency at the community level that will establish the demonstration project. The task force may appoint additional sub-committees as deemed indicated.

At the community level a Steering Committee will be developed with provider and consumer representatives from the community. The major agencies involved in the Project will have representation.

A Project Director from the lead agency will be appointed during this developmental period for the Project. Project Director will be responsible for planning and developing the Project.

Staff will be "pooled" from the three major provider agencies and other agencies as needed.

The staff would be provided by the existing agencies under Memorandums of Agreement. New staff for this function would be minimal as many services may already be in operation. Service components would be integrated at a central intake point of entry.

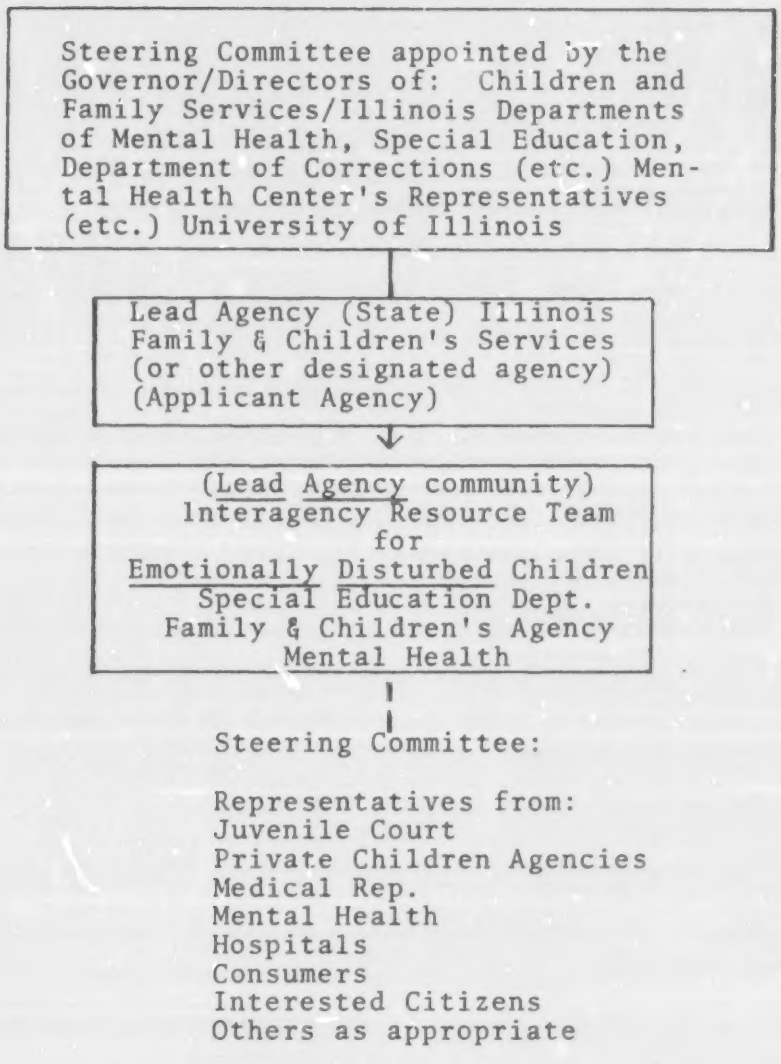
There must be an agreed upon written service plan. Functions would be assigned to identified staff members within the provider group. These functions include: 1) diagnosis and evaluation; 2) case planning, coordination, developing a service plan; and 3) facilitating all services arrangements for the child and his family.

ORGANIZATIONAL STRUCTURE

INTER-AGENCY COOPERATIVE PROGRAM FOR

EMOTIONALLY DISTURBED

CHILDREN


Steering Committee appointed by the Governor/Directors of: Children and Family Services/Illinois Departments of Mental Health, Special Education, Department of Corrections (etc.) Mental Health Center's Representatives (etc.) University of Illinois
Lead Agency (State) Illinois Family & Children's Services (or other designated agency) (Applicant Agency)
(Lead Agency community) Interagency Resource Team for Emotionally Disturbed Children Special Education Dept. Family & Children's Agency Mental Health
Steering Committee:
Representatives from:
Juvenile Court
Private Children Agencies
Medical Rep.
Mental Health
Hospitals
Consumers
Interested Citizens
Others as appropriate

VII

VI. GOVERNOR'S YOUTH SERVICE INITIATIVE*

A. Program Description

The Governor's Youth Services Initiative proposes the expansion of the unique state program to serve adolescents who have previously fallen through the cracks of the various service delivery systems. It is a cooperative venture involving the executive, judicial, and legislative branches of government.

The initial Governor's Cook County Court Project was developed in the Summer of 1979 to provide services to a group of youth under the jurisdiction of the Juvenile Court. The target population was youth with multiple problems who do not meet the client criteria of any individual state agency to whom the court makes referrals, or who partially meet the criteria of several agencies. Historically, such youth were referred from one agency to another and often received inappropriate services or no services at all. For example, a youth may need mental health services but also be abused and require placement. The Department of Mental Health (DMH) may not have an appropriate placement and the Department of Children and Family Services (DCFS) may not have appropriate mental health services.

The project was originally proposed by the Office of the Governor in the interest of this population of children who were known to the Cook County Juvenile Court and who required additional child welfare, educational, and/or mental health services but who were not accepted for such services by state agencies. The project was developed and implemented in August of 1979 as a pilot demonstration program in Cook County and expanded to include, in addition to DCFS and DMH, the Department of Corrections and the State Board of Education.

The project was conceived as a pilot demonstration project with an evaluation during the first year and an eventual expansion to other counties. Operations were begun in August of 1979 and a permanent project director was appointed in November, 1979.

Children defined as in need of service by the court are accepted without decline by the executive branch for services when they meet one of the following three criteria:

- All regular channels designed to elicit service have been exhausted.
- There is major disagreement between the court and state agency as to the state agency's responsibility for a child and the type of service the child is to receive.
- There is major disagreement between two state agencies as to which agency is responsible for service delivery.

*1981 Plan Phase I: 1979-81, Human Services Plan/Vol. I.

The project operates through an interagency team with representatives of DCFS, DMH, DOC, the Juvenile Court, educational services, and the project director. The team develops a treatment plan and holds regular staffings on each case. The project staff function as a case manager and coordinate the services of these agencies through regular meetings to ensure that each youth receives appropriate services. Cases are identified by court staff and referrals are made by the chief judge.

Twenty-four youths have been referred to the project from August, 1979 to April, 1980. The project may have an impact on youth beyond the number of cases served directly. The various agencies may be accommodating many of the youths from the target population in response to the project in order to avoid the procedures and implications of the project.

The youngsters served range in age from 13 years to 17½ years and can best be described as behaviorally disordered/emotionally disturbed, frequently with an overlay of developmental disability including epilepsy and/or mild to moderate retardation. Most of these clients have been found to be in need of special education services and many have already been found tuitionable for registered non-public educational programming.

Since this is a court initiated and involved project, all of the children are known to the Cook County Juvenile Court System; many have juvenile records including prostitution, burglary, deviant sexual acts, assault, armed robbery, and shoplifting. In addition, records frequently include histories of polydrug and alcohol abuse and runaway activity. Previous placements in child welfare settings and/or psychiatric hospitals have occurred in all the cases reviewed to date.

Typically, families are multi-problemed and lack emotional and financial resources. They in turn have been known to DCFS/Child Welfare System for physical and sexual abuse, neglect and/or dependency. Others are known to have long standing mental health problems and some small number are or have been in adult correctional programs. It is not unusual for a family to have been involved in the system multi-generationally.

B. Program and Service Data

Program Data	FY 79 Actual	FY 80 Estimated	FY 81 Projected
1. Expenditures ($000's)	----	----	1,210.0
2. Obligational Authority ($000's)	----	----	1,210.0
3 Performance Indicators			
a. Percent of Children for whom an inter-agency service plan is developed	----	----	100%
b. Percent of Children who achieve goals of service plan	----	----	96%
Services Data			
1. Recipient			
Multi-Problem Children Served	----	----	100

C. Program Analysis and Directions

Initial results of the Cook County Court Project indicate its success:

.The public agencies have successfully worked together to develop treatment plans for each child referred. Hence, the inter-agency "gap" has been largely closed.

.96% of the youth accepted by the program have been making successful progress toward achieving the goals of their service plans. Only one of the 24 youth has failed in his treatment situation and in this case an alternative plan has been developed.

.There is evidence that due to the existence of the Project, the state agencies are more responsive to accepting referrals from the court without Project involvement.

Due to the success of the Cook County Court Project the State will seek replication of the project in four other Illinois areas in the fiscal year 1981. The cost will be $1.21 million. Coordinators will be hired to administer the program in each area. These coordinators will serve the following functions:

.Organization of inter-agency projects and facilitation of inter-agency coordination and cooperation

.Ensurance that each case obtains an appropriate individual treatment plan and receives necessary services

.Liaison with the Governor's Office

.Negotiation/adjudication of conflicts between agencies over service provision

.Facilitation of all inter-agency meetings

.Provision of leadership for many individual case staffings

.Constant availability to resolve individualized problems.

The majority of the funds will be "flexible service" dollars. This means that the coordinator will be able to purchase or develop services not usually available in the community or through the regular budget allocations of the state agencies. Request for Proposals will be sent to the private residential sector in Illinois. These proposals will request the initiation of a number of 5-8 bed units for multi-problem children and adolescents needing intensive services. Support and treatment services to the client's family will be developed in conjunction with these new initiatives.

Each area's program will have representatives from the state Departments of Children and Family Services, Mental Health and Developmental Disabilities, Corrections, the Juvenile Court and Education. The private sector will be involved in case planning for children and in developing the needed service resources. Agency representatives will be experienced social service administrators, appointed by the department directors. They will have the authority to act as final spokespersons and decision-makers for their agency. A representative of the County Juvenile Court will be appointed by the presiding judge and will serve at his or her discretion.

The Department is committed to continuing to explore new initiatives to strengthen the state's service system for youth in crisis. This area will be discussed in more detail in Phase II of the 1981 Illinois Human Service Plan to be published in Summer, 1980.

REPRODUCED BY IL COMMISSION ON CHILDREN

VIII

Continuum of Services

I. Direct Services

A. Inpatient treatment.

1. Psychiatric hospitalization: provide highly intensive treatment often in response to acute incidents of seriously disturbed behavior in a setting which can insure the safety of the patient and those around him.
2. Long term residential care: provide consistency of care and treatment for a sufficient period to allow for the amelioration of chronic conditions particularly when the child's natural environment proves insufficient in meeting his needs.
3. Short term residential care: provide consistency of care and comprehensive treatment with the prompt return to a less restrictive setting as an intrinsic part of the treatment plan.
4. Crisis or emergency placement: provide intensive intervention without delay frequently in response to an acute intense outburst of disturbed behavior. Frequently emergency placement is designed to prevent the individual from becoming a danger to himself or others.
5. Partial hospitalization: provide the optimal mixture of a therapeutic environment or treatment setting and the "real world" with both aspects carefully considered in a treatment plan.
6. Transitional facilities/placement (this is between in-patient and out-patient or between two types of intervention settings, e.g. detention centers cf. public school and home): insure the successful change from a more restrictive setting to a less restrictive setting without engendering a return to less adaptive patterns of behavior.

B. Out-patient therapeutic services.

1. Individual therapy: to personalize therapeutic intervention to the specific psychological characteristics of the individual client.
2. Group therapy: to maximize therapeutic gains through the mutually interactive aspects of group process.
3. Family therapy: to capitalize upon characteristics of the family as the most critical primary group for most people in developing a treatment process which emphasizes the family as a system.
4. Crisis intervention: to provide resource personnel skilled in handling acute situations themselves or in establishing linkages between people in pain and resources. Prompt service without delay is a critical goal.

5. Psychopharmacological treatment: to enable the individual to cope more effectively with his environment either by making it possible for him to independently employ his own adaptive capabilities more effectively or in conjunction with therapeutic intervention. In some situations psychotrophic drugs are used to reduce the risk the individual presents to himself or others.
6. Specialized services for minority groups including, for example, alienated groups, e.g. migrant workers, refugees: to provide reality based intervention which recognizes and seeks to encompass those factors which place certain groups out of the "mainstream" of society.
7. Follow-up care - post hospitalization: to ensure successful transition from the hospital setting to a less restrictive setting (often the pre-hospitalization environment) without a return to those behaviors which led to hospitalization.

C. Family support.

1. Family therapy: see B.3.
2. Supportive services: provide resources needed to allow the family to function more effectively.
3. Educational services (e.g. parenting training): provide specific skills, modified expectations and alternative models in order to enhance the family's ability to function.
4. Consultative services: identify the needs of the family, locate the resources needed to meet those needs and provide ways and means of access to the resources.
5. Respite care: provide an opportunity for the members of the family to regain strength and perspective by making short term care for the identified patient available.
6. Day care: provide a treatment modality for the young client and/or to make possible for the adult members to meet its economic needs.

D. Family Alternatives.

1. Group homes: to provide a family surrogate, often in a pseudo-family model, where alternative modes of dealing with various problems can be learned.
2. Foster care: to provide a family setting which will allow re-parenting to occur in ways which will permit the client to learn more effective coping strategies.
3. Adoption: to provide a permanent relocation of the client to a family setting which can better handle his needs.
4. Residential placement: under particular circumstances residential placement may function as a family alternative (see A.1 and 2).

E. Services to specialized groups.

1. See B.6.
2. Substance abuse treatment: to develop alternatives coping strategies other than the reliance upon the psychological and physiological effects of certain psychoactive substances and to break out of certain social patterns of dependence upon particular subcultural groups.
3. Adolescent services - e.g. drop-in-centers for alienated youth, etc.: to provide short term problem oriented assistance within the setting of the adolescents's day-to-day environment.
4. Preschool day treatment, therapeutic nurseries: to provide early intervention in a group setting specifically adapted to the age and developmental level of the clients.

F. Educational services.

1. Full spectrum of special educational services and programs for socially maladjusted children and behavior disordered children: to provide educational programs modified and specialized in nature and extent to foster maximum development of the children.
2. Supportive services: to provide resource personnel to children, families and school staff.
3. In-service training: to help regular instructional staff deal more effectively with emotionally disturbed children in terms of both identification and treatment.

II. Universal services.

A. Health ensuring services.

B. Educational services.

C. Identification services.

D. Awareness programs directed toward both the public at large and specific groups in particular, such as educators.

III. Enabling Services.

A. Consultation

B. Coordination.

C. Accountability and evaluation.

D. Research.

E. Training.

QUESTIONNAIRE MAILED TO SELECTED REPRESENTATIVES OF THE PRIVATE AGENCIES.

Date: April 2, 1979. Number Mailed: 44 Number Returned: 18

Purpose was to give private agency leaders an opportunity to state their opinions and views regarding the respective roles of public and private agencies in meeting the needs of emotionally disturbed children. They were asked to respond to the following statements:

Statement A. "In considering the problems and needs of emotionally disturbed children and adolescents in my region of Illinois, I regard the following types of services as needing the most attention and development."

Respondents identified many types of services which were needed in their regions and which, together, comprise a continuum from "early identification" to "after care services." Most frequently listed services were the following:

Early diagnostic services and identification of treatment programs appropriate for individuals. Needed are comprehensive services provided by professionally competent individuals and agencies.

Counseling services for families, children, adolescents.

Alternative education programs; vocational programs which are individualized and treatment-oriented.

Specialized foster homes.

Various forms of residential care for those "unable to be mainstreamed and who need intensive, personalized, educational, social service, and treatment programs."

After-care and transitional services for those who have been in residential care.

Emergency care - and closed residential care - for severely disturbed, acting-out adolescents, for purposes of treatment and protection.

Statement B. "Private agencies should take the initiative and be responsible for developing and providing the following types of services to emotionally disturbed children and adolescents."

Respondents indicated that private agencies should be encouraged to develop almost all services required for this target population with the provision that adequate support, funding, and competent monitoring was available through state agencies. Most answers did not cite closed residential care as being appropriate for the private social welfare agency. Many underscored the desirability of private agencies developing and maintaining most direct service programs in collaboration with the public agencies.

Highlights:

"All services should be provided by private agencies in coordination with a network of services in each community. Government mandated services should be delivered by contracting with the private sector."

"Primate agencies should provide a continuum of care from in-home treatment to foster care, group and residential care, and after care."

"Infant and pre-school day care facilities with in-house social work staff to detect and treat children and families in cases where children are showing early signs of emotional disturbance."

"It is my feeling that the private sector should be providing most, if not all, direct services and the state agencies delegated a monitoring function."

"Private agencies should offer a range of independent living opportunities for older adolescents, both those who have received service and those who fell through the cracks earlier."

Private agencies should be a "resource to public agency in the development of treatment plans for children."

"One of the most crucial areas needing to be addressed is after-care so there is continuity and support in the post discharge environment."

Statement C. "Public agencies should take the initiative and be responsible for developing the following types of services to emotionally disturbed children and adolescents."

Most consistently in the responses, the public agencies were seen as having significant roles in overall planning for services; contracting and funding for programs; monitoring; providing accurate and timely data; offering programs in direct care for high-risk, severely disturbed, mentally ill children, and for emergency care. It was generally conceded that the public agency was in the best position to provide long-term care for those children requiring closed, protective care indefinitely.
Highlights:

The public agency responsibility was identified in "development of a comprehensive system of assessing children's needs which will make services available to those who fail to receive services from anyone because they do not meet necessary criteria, i.e., too severe for one service, not severe enough for another."

"Take more of a role in monitoring, overseeing, providing accountability - contracting with private agencies."

"Provide accurate data on troubled children - so both public and private sectors can be effective."

Public agencies should provide "Closed residential care for emotionally disturbed adolescents... and long-term residential care for those with demonstrated poor prognosis for acceptable social adjustment in the open community...for those who cannot live in open settings and who represent a significant threat to themselves and/or society."

"At least in the metropolitan area, develop a diagnostic unit with clinically trained staff."

"Provide adequate and available funding for needed programs."

"Develop status offender programs."

Develop a "service delivery system that guarantees a child will be followed until self-sufficiency has been reached."

Carry the "advocacy role with the legislature and the federal government to obtain adequate support and funds."

Maintain "community mental health care as a referral/support network to residential care...medical services for children in placement."

Question D. "Special conditions that would have to be met for private agencies to develop new and expanded programs for this target population."

Answers point to a willingness on the part of private agencies to develop additional, specialized services if there can be developed and maintained a common philosophy and commitment toward services; a cooperative relationship among public and private agencies; a supportive climate emanating from the governor, legislature, and federal officials. Funding is required for the construction, purchase, renovation of facilities; for start-up costs; as well as for full reimbursement for costs of on-going programs. Local communities must provide permissive zoning laws and building codes. Private agencies need capable lay Boards and community support, as well as basic, solid financial backing. Highlights:

There must be a "Positive relationship between the public and private sectors."

The private agency must have "A well-informed, active, and dedicated lay board." It needs "strong community support and/or acceptance of the agency's role in helping these children."

Required is "professional staff to provide services."

There must be "significant success in networking involving public and private agencies."

Important is a "cooperative attitude for all parties to strive together to develop and make available programs for this population...A cooperative clearing house of information regarding services needed and programs available."

"Clear definition of role public sector will play...Provision of lead time for private agencies to gear up...development and agreement of contract specifications - early so private agencies will be assured new services will be utilized...Realistic dollars provided with special rates and formulas that allow for differential needs."

"Joint planning based on common philosophy and in regard to need."

"Funding for the development, purchase, and renovation of existing properties...Operation funding for residential as well as outpatient counseling, specialized foster homes."

Public commitment needed so that "in spite of legislative restraint on one-year contracts, agencies can feel they are developing programs with a future."

Questionnaires were mailed to the following:

D. Coyd Taggart, Homes for Children, Park Ridge.
Gene B. Meier, Lawrence Hall School for Boys, Chicago.
Alice James, Children's Home & Aid Society of IL, Chicago.
Ray Fannings, Chicago Child Care Society, Chicago.
Marion Obenhaus, Chicago Child Care Soceity, Chicago.
Seymour J. Adler, Methodist Youth Services, Chicago.
Alton M. Broten, Mary Bartelme Homes, Chicago.
Robert Holway, Allendale School for Boys, Chicago.
Donald R. Donica, Central Baptist Children's Home, Lake Villa.
Thomas L. Pfeiffer, Arden Shore Assn., Lake Bluff.
Everett Petlicki, Catholic Charities, Chicago.
Rev. Thomas Holbrock, Catholic Charities, Chicago.
Benjamin Finley, Afro-American Family & Community Services, Chicago.
Nancy Johnstone, Youth Guidance, Chicago.
Reuben Jessop, Lutheran Social Services of IL., Chicago.
Gene Svebakken, Lutheran Child & Family Services, River Forest.
Charles Banning, Kemmerer Village, Assumption.
Thomas Powell, Cunningham Children's Home, Urbana.
Merlin Outcalt, Webster - Cantrell Hall, Decatur.
Joe Jenkins, Child and Family Services, Chicago.
Kenneth Viggers, Childrens Home of Peoria, Peoria.
Gene Simon, Chaddock Boys School, Quincy.
George Headley, Chapin Hall for Children, Chicago.
Henry Suozzi, Counseling & Family Services, Peoria.
Doris Wheeler, Evangelical Child and Family Agency, Chicago.
Larry Lee, Family Service Center of Sangamon Cty., Springfield.
Rev. Paul Schippel, Hoyleton Children's Home, Hoyleton.
Curtis Mooney, Hudelson Baptist Children's Home, Centralia.
Judith Schild, Jewish Children's Bureau, Chicago.
Melvin Breed, Kaleidoscope, Bloomington.
Rev. Karl Hepler, Kings Daughters Homes for Children, Freeport.
Michael Hoewitz, Larkin Home for Children.
Reginald Hanks, Lt. Jos. Kennedy, Jr. School, Palos Park.
Rev. John P. Smyth, Maryville Academy, Des Plaines.
Capt. Carol Bryant, Booth Memorial Hospital, Chicago.
Bruce McQuaker, Travelers Aid Society, Chicago.
Joseph P. Munday, Uhlich Home, Chicago.
Lee Hout, Bethany Home, Moline.
Rev. Marion Farmer, United Methodist Children's Home, Mt. Vernon.
John A. Halsey, Youth Enrichment Services, Chicago.
Lorraine Fox, Crisis Home, Park Ridge.
Leon Talley, Baptist Children's Home, Carmi.
James Simmons, Volunteers of American, Chicago.
Robert Ralls, Child Care Assn. of Illinois, Springfield.

QUESTIONNAIRE MAILED TO SELECTED REPRESENTATIVES OF PRIVATE AGENCIES.

Date: December 31, 1979 Number Mailed: 40 Number Responding: 21

This was a second questionnaire sent to these individuals. This asked for reactions to the Findings, Recommendations, etc., developed by the Committee. Some responses reiterated those coming with the first mailing; some presented new ideas. There was little disagreement with what had been developed by the Committee.

Findings

1. The limited, year-to-year decisions regarding funding by public agencies makes planning and program development extremely difficult for private agencies.

2. Lack of public funds for capital expense in the private sector makes development of new facilities difficult - and makes it impossible for the smaller, poorly endowed agency.

3. In spite of efforts to the contrary, basic mistrust exists between many public and private agencies; there is a lack of communication on a meaningful level; there is active disagreement over the kinds and amounts of services to be provided for emotionally disturbed children.

4. Schools are being asked to carry new and heavier responsibilities and are not prepared or suited for them; schools are too often seen as resources to solve all problems of society - and they cannot do that.

5. Lack of on-going planning, and of day-to-day coordination, between and among the various state agencies complicates the service delivery system; various, differing requirements by each agency are problems for private agencies attempting to work with more than one such agency; there are unresolved conflicts concerning mandated responsibilities; changes in public leadership are so rapid and frequent, with resultant changes in policies and directions, that private agencies are often at a loss as to what program development to pursue in relation to the public agency need.

6. Availability of services varies greatly from region to region; state-wide policies are not evenly applied.

7. There is too little emphasis on "what does the child need?" and too much on "where can we put the child at the least possible cost?"

Recommendations

1. We must develop a system that is capable of determining what a child needs and what is the most appropriate way (s) of meeting those needs - and of expending effort and funds to locate such resources.

2. There must be assured public funding, over a multi-year period, for both capital development and operation. Capital funding should be a joint effort with the private sector, with clear guidelines developed.

3. "Given the present system (private agencies depending upon public policies and funding), a method must also be developed which will insure that there is a common planning program for both sectors and that what is espoused as policy on one date will be consistent when the actual program is produced. A lack of trust between the public and private sectors would seem to be a major problem to be overcome."

4. Develop specific ways for private agencies, or coalitions, to have input to the Governor's Human Service Sub-Cabinet and to the state budgeting process -- on a regular basis.

5. Encourage and strengthen Advisory Committees to human service state agencies.

6. Establish a state-wide or metropolitan-wide "Case Review Committee" to develop plans or recommendations for those "hard to place" children.

7. Encourage private agencies to develop multi-services, to provide for more options for help within a single operation.

8. Simplify and standardize DCFS, DMH/DD, DPA, IOE, and other state agency procedures, forms, budgets, reporting systems, applications -- and relate them to those of United Way.

9. "There should be one state agency with full and final authority to look after children," and with full authority to utilize services of other state agencies as needed to meet the needs of those children. "All other state agencies dealing with children ought to be mandated and funded to respond to whatever that plan calls for."

10. "It is unwise to recommend that responsibility for no-decline service rests with public agency...I feel that the public agency should provide necessary financial and technical assistance to the private sector to develop these services."

Agency Interests in Expanded Services

1. Regular and specialized foster family care.

2. Day treatment programs.

3. Family and individual treatment/counseling/in-home services.

4. Residential treatment programs.

5. Add to present residential programs: vocational services, more intensive professional staffing pattern; psychiatric and psychological services; stronger recreation programming; added special education teachers.

6. Group homes.

7. Semi-independent living program for older adolescents; temporary maintenance.

8. Emergency care for troubled youngsters.

9. Closed treatment program.

10. Small, closed, and medically supervised respite care facility.

11. Preventative treatment groups.

Conditions Required for Expansion

1. Purchase of service fees/grants sufficient to provide the kind of staffing necessary; assurance that base amount of support would facilitate long range planning; a system that allows inclusion of costs for new personnel into rate negotiations on a timely basis.

2. Commitments that new and expanded programs will be utilized; that referrals will be appropriate.

3. Enabling legislation providing support and protection for staff and agency.

4. Steadfast commitment by public agency to explore and utilize options that are always in the best interests of the child -- and are not what is only convenient, inexpensive, available.

5. Adequate funding from start-up. Assistance with capital costs as well as operation.

6. "Process for embarking on new program areas needs to be unemcumbered by bureaucratic red tape and multi-public agency approval."

7. Clearly defined policies regarding the responsibilities of referring agency and the provider agency.

APPENDIX X

IL REV. STAT., ch. 23, §5001, et. seq., "Department of Children and Family Services"

5001. Purpose

§ 1. The purpose of this Act is to create a Department of Children and Family Services to provide social services to children and their families, to operate children's institutions, and to provide certain other rehabilitative and residential services as enumerated in this Act.

5005. Direct child welfare services

§ 5. To provide direct child welfare services when not available through other public or private child care or program facilities. For purposes of this Section:

The term "children" means persons found within the State who are under the age of 18 years. The term also includes persons under age 21 who (1) were committed to the Department pursuant to the "Juvenile Court Act", approved August 5, 1965, as amended,[1] prior to the age of 18 and who continue under the jurisdiction of the court, or (2) were accepted for care, service and training by the Department prior to the age of 18 and whose best interest in the discretion of the Department would be served by continuing that care, service and training because of severe emotional disturbances, physical disability, social adjustment or any combination thereof, or because of the need to complete an educational or vocational training program.

The term "child welfare services" means public social services which supplement or substitute for parental care and supervision for the purpose of: (1) preventing or remedying or assisting in the solution of problems which may result in the neglect, abuse or exploitation of children; (2) protecting and caring for homeless, dependent or neglected children; (3) protecting and promoting the welfare of children, including the strengthening of their own families and counseling of family members; (4) providing adequate care of children away from their homes, where needed, in foster family homes or day care or other child care facilities; or (5) providing counseling for mentally retarded, physically, and socially handicapped children and their parents when not otherwise available.

The Department shall establish and maintain tax-supported child welfare services and extend and seek to improve voluntary services throughout the State, to the end that services and care shall be available on an equal basis throughout the State to children requiring such services.

5005a. Reimbursable services

§ 5a. Reimbursable services for which the Department shall pay 100% of the reasonable cost pursuant to a written contract negotiated between the Department and the agency furnishing the services (which shall include but not be limited to the determination of reasonable cost, the services being purchased and the duration of the agreement) include, but are not limited to:

SERVICE ACTIVITIES

Adjunctive Therapy;
Child Care Service;
Clinical Therapy;
Custodial Service;
Field Work Students;
Food Service;
Normal Education;
In-Service Training;
Intake or Evaluation, or both;
Medical Services;
Recreation;
Social Work or Counselling, or both;
Supportive Staff;
Volunteers.

OBJECT EXPENSES

Professional Fees and Contract Service Payments;
Supplies;
Telephone and Telegram;
Occupancy;
Local Transportation;
Equipment and Other Fixed Assets;
Miscellaneous.

ADMINISTRATIVE COSTS

Program Administration;
Supervision and Consultation;
Postage and Shipping;
Outside Printing, Artwork, etc.;
Subscriptions and Reference Publications;
Management and General Expense;

Reimbursement of administrative costs may not exceed 20% of the costs for other services.

The Department may pay 100% of the reasonable costs of research and valuation focused exclusively on services to wards of the Department of Children and Family Services. Such research projects must be approved, in advance, by the Director of the Department.

Added by P.A. 79-1481, § 1, eff. Sept. 13, 1976

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IL REV. STAT., ch. 23, §2051 et. seq., "Abused and Neglected Child Reporting Act"

2052. Protective services—Application of act to residents of public or private institutions

§ 2. The Illinois Department of Children and Family Services shall, upon receiving reports made under this Act protect the best interests of the child, offer protective services in order to prevent any further harm to the child and to other children in the family, stabilize the home environment and preserve family life whenever possible. Recognizing that children also can be abused and neglected while living in public or private residential agencies or institutions meant to serve them, this Act also provides for the reporting and investigation of child abuse and neglect in such instances. In performing any of these duties, the Department may utilize such protective services of voluntary agencies as are available.

Amended by P.A. 81-1077, § 1, eff. July 1, 1980.

2057.1. Cooperation of other agencies

§ 7.1. To the fullest extent feasible, the Department shall cooperate with and shall seek the cooperation and involvement of all appropriate public and private agencies, including health, education, social service and law enforcement agencies, courts of competent jurisdiction, and agencies, organizations, or programs providing or concerned with human services related to the prevention, identification or treatment of child abuse or neglect.

Such cooperation and involvement shall include joint consultation and services, joint planning, joint case management, joint public education and information services, joint utilization of facilities, joint staff development and other training, and the creation of multidisciplinary case diagnostic, case handling, case management, and policy planning teams.

Added by P.A. 81-1077, § 1, eff. July 1, 1980.

2057.3. Investigations—Responsibilities of department

§ 7.3. The Department shall be the sole agency responsible for receiving and investigating reports of child abuse or neglect made under this Act, except that the Department may delegate the performance of the investigation to a local law enforcement agency and to those private social service agencies which have been designated for this purpose by the Department prior to the effective date of this amendatory Act of 1979.

Added by P.A. 81-1077, § 1, eff. July 1, 1980.

2058.2. Service plan

§ 8.2. If the Child Protective Service Unit determines that there is probable cause to believe the child is abused or neglected, based upon its determination of the protective, treatment, and ameliorative service needs of the child and family, the Child Protective Service Unit shall develop, with the family, an appropriate service plan for the family's voluntary acceptance or refusal. The Child Protective Service Unit shall comply with Section 8.1 [1] by explaining its lack of legal authority to compel the acceptance of services and may explain its concomitant authority to petition the Circuit Court under the "Juvenile Court Act" [2] or refer the case to the local law enforcement authority, State's attorney, or criminal court.

Added by P.A. 81-1077, § 1, eff. July 1, 1980.

[1] Paragraph 2058.1 of this chapter.
[2] Chapter 37, ¶ 701-1 et seq.

2061.5. Continuing education program

§ 11.5. Within the appropriation available, the Department and the Child Protective Service Unit, both jointly and individually, shall conduct a continuing education and training program for State and local staff, persons and officials required to report, the general public, and other persons engaged in or intending to engage in the prevention, identification, and treatment of child abuse and neglect. The program shall be designed to encourage the fullest degree of reporting of known and suspected child abuse and neglect, and to improve communication, cooperation, and coordination among all agencies in the identification, prevention, and treatment of child abuse and neglect. The program shall inform the general public and professionals of the nature and extent of child abuse and neglect and their responsibilities, obligations, powers and immunity from liability under this Act. It may include information on the diagnosis of child abuse and neglect and the rules and procedures of the Child Protective Service Unit, the Department and central register, the courts and of the protective, treatment, and ameliorative services available to children and their families. The program may also encourage parents and other persons having responsibility for the welfare of children to seek assistance on their own in meeting their child care responsibilities and encourage the voluntary acceptance of available services when they are needed. It may also include publicity and dissemination of information on the existence and number of the 24 hour, State-wide toll-free telephone service to assist persons seeking assistance and to receive reports of known and suspected abuse and neglect.

Added by P.A. 81-1077, § 1, eff. July 1, 1980.

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IL REV. STAT., ch. 23, §2211 et. seq., "Child Care Act"

2215. Licenses and permits

Examination of personnel and facilities

§ 5. (a) In respect to child care institutions, maternity centers, child welfare agencies, day care centers, group homes and night-time centers, the Department, upon receiving application filed in proper order, shall examine the facilities and persons responsible for care of children therein.

Applicant agencies

(b) In respect to foster family and night-time homes, applications may be filed on behalf of such homes by a licensed child welfare agency, by a State agency authorized to place children in foster care or by out-of-State agencies approved by the Department to place children in this State. In applying for license in behalf of a home in which children are placed by and remain under supervision of the applicant agency, such agency shall certify that the home and persons responsible for care of unrelated children therein were found to be in reasonable compliance with standards prescribed by the Department for the type of care indicated.

Persons authorized to make examinations

(c) The Department shall not allow any person to examine facilities under a provision of this Act who has not passed an examination demonstrating that such person is familiar with this Act and with the appropriate standards and regulations of the Department.

Form and term of licenses

(d) Licenses shall be issued in such form and manner as prescribed by the Department and are valid for 2 years from the date issued, unless revoked by the Department or voluntarily surrendered by the licensee.

Issuance of permits

(e) The Department may issue one 6-month permit to a newly established facility for child care to allow that facility reasonable time to become eligible for a full license. If the facility for child care is a foster family home, day care home or night-time home, the Department may issue one 2-month permit only.

Visitation

(f) During the hours of operation of any licensed child care facility, authorized representatives of the Department may without notice visit the facility for the purpose of determining its continuing compliance with this Act or regulations adopted pursuant thereto.

Amended by P.A. 79-1454, § 8 eff. Aug. 31, 1976.

2217. **Minimum standards for licensing of facilities**

§ 7. (a) The Department must prescribe and publish minimum standards for licensing that apply to the various types of facilities for child care defined in this Act and that are equally applicable to like institutions under the control of the Department and to foster family homes used by and under the direct supervision of the Department. The Department shall seek the advice and assistance of persons representative of the various types of child care facilities in establishing such standards. The standards prescribed and published under this Act take effect as provided in "An Act concerning administrative rules", approved June 14, 1951, as amended,[1] and are restricted to regulations pertaining to:

(1) The operation and conduct of the facility and responsibility it assumes for child care;

(2) The character, suitability and qualifications of the applicant and other persons directly responsible for the care and welfare of children served;

(3) The general financial ability and competence of the applicant to provide necessary care for children and to maintain prescribed standards;

(4) The number of individuals or staff required to insure adequate supervision and care of the children received;

(5) The appropriateness, safety, cleanliness and general adequacy of the premises, including maintenance of adequate fire prevention and health standards conforming to State laws and municipal codes to provide for the physical comfort, care and well-being of children received;

(6) Provisions for food, clothing, educational opportunities, program, equipment and individual supplies to assure the healthy physical, mental and spiritual development of children served;

(7) Provisions to safeguard the legal rights of children served;

(8) Maintenance of records pertaining to the admission, progress, health and discharge of children;

(9) Filing of reports with the Department;

(10) Discipline of children;

(11) Protection and fostering of the particular religious faith of the children served.

Department of Mental Health and Developmental Disabilities, advice

(b) If, in a facility for general child care, there are children diagnosed as mentally ill, mentally retarded or physically handicapped, who are determined to be in need of special mental treatment or of nursing care, or both mental treatment and nursing care, the Department shall seek the advice and recommendation of the Department of Mental Health and Developmental Disabilities, of the Department of Public Health or of both Departments regarding the residential treatment and nursing care provided by the institution.

Consultation and assistance

(c) The Department, in applying standards prescribed and published, as herein provided, shall offer consultation through employed staff or other qualified persons to assist applicants and licensees in meeting and maintaining minimum requirements for a license and to help them otherwise to achieve programs of excellence related to the care of children served.

Licensing standards summaries

(d) The Department shall prepare summaries of licensing standards. Each licensee or holder of a permit for a child care facility shall distribute a copy of the appropriate summary to the legal guardian of each child cared for in that facility at the time when the child is enrolled or initially placed in the facility.

Amended by P.A. 79-844, § 1, eff. Oct. 1, 1975.

[1] Chapter 127, ¶ 263 et seq. (repealed)

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IL REV. STAT., ch. 37, §701 et. seq., "The Juvenile Court Act"

705-2. Kinds of dispositional orders

§ 5-2. Kinds of Dispositional Orders. (1) The following kinds of orders of disposition may be made in respect of wards of the court.

(a) A minor found to be a delinquent under Section 2-2[1] may be (1) put on probation or conditional discharge and released to his parents, guardian or legal custodian; (2) placed in accordance with Section 5-7,[2] with or without also being put on probation or conditional discharge; (3) where authorized under the "Drug Addiction Act",[3] ordered admitted for treatment for drug addiction by the Department of Mental Health and Developmental Disabilities; (4) committed to the Department of Children and Family Services subject to Section 5 of "An Act creating the Department of Children and Family Services, codifying its powers and duties, and repealing certain Acts and Sections herein named",[4] except that the limitations of said Section 5 shall not apply on or after July 1, 1973 to a delinquent minor under 13 years of age; (5) committed to the Department of Corrections under Section 5-10,[5] if he is 13 years of age or older, provided that minors less than 13 years of age may be committed to the Department of Corrections until July 1, 1973; and provided further that commitment to the Department of Corrections, Juvenile Division, shall be made only if a term of incarceration is permitted by law for adults found guilty of the offense for which the minor was adjudicated delinquent; (6) ordered partially or completely emancipated in accordance with the provisions of the "Emancipation of Mature Minors Act", enacted by the Eighty-First General Assembly;[6] or (7) placed in detention for a period not to exceed 30 days.

(b) A minor under 18 years of age found to be in need of supervision under Section 2-3[7] may be (1) committed to the Department of Children and Family Services, subject to Section 5 of "An Act creating the Department of Children and Family Services, codifying its powers and duties, and repealing certain Acts and Sections herein named", except that the limitations of said Section 5 shall not apply on or after January 1, 1974, to a minor so adjudicated under paragraph (d) of Section 2-3 of this Act; (2) placed under supervision and released to his parents, guardian or legal custodian; or (3) placed in accordance with Section 5-7 with or without also being placed under supervision. Conditions of supervision may be modified or terminated by the court if it deems that the best interests of the minor and the public will be served thereby. A minor in need of supervision by reason of his addiction, described in paragraph (c) of Section 2-3, may be placed under the treatment supervision of the Department of Mental Health and Developmental Disabilities instead of or in addition to the disposition provided for in this paragraph; or (4) ordered partially or completely emancipated in accordance with the provisions of the "Emancipation of Mature Minors Act", enacted by the Eighty-First General Assembly.

(c) A minor under 18 years of age found to be neglected under Section 2-4[8] may be (1) continued in the custody of his parents, guardian or legal custodian, or (2) placed in accordance with Section 5-7; or (3) ordered partially or completely emancipated in accordance with the provisions of the "Emancipation of Mature Minors Act", enacted by the Eighty-First General Assembly.

However, in any case in which a minor is found by the court to be neglected under Section 2-4 of this Act and the court has made a further finding under paragraph (2) of Section 4-8[9] that such neglect is the result of physical abuse, custody of the minor shall not be restored to any parent, guardian or legal custodian found by the court to have inflicted physical abuse on the minor until such time as a hearing is held on the issue of the fitness of such parent, guardian or legal custodian to care for the minor and the court enters an order that such parent, guardian or legal custodian is fit to care for the minor.

(d) A minor under 18 years of age found to be dependent under Section 2-5[10] may be (1) placed in accordance with Section 5-7; or (2) ordered partially or completely emancipated in accordance with the provisions of the "Emancipation of Mature Minors Act", enacted by the Eighty-First General Assembly.

However, in any case in which a minor is found by the court to be dependent under Section 2-5 of this Act and the court has made a further finding under paragraph (2) of Section 4-8 that such dependency is the result of physical abuse, custody of the minor shall not be restored to any parent, guardian or legal custodian found by the court to have inflicted physical abuse on the minor until such time as a hearing is held on the issue of the fitness of such parent, guardian or legal custodian to care for the minor and the court enters an order that such parent, guardian or legal custodian is fit to care for the minor.

(2) Any order of disposition other than commitment to the Department of Corrections may provide for protective supervision under Section 5-4[11] and may include an order of protection under Section 5-6.[12]

(3) Unless the order of disposition expressly so provides, it does not operate to close proceedings on the pending petition, but is subject to modification until final closing and discharge of the proceedings under Section 5-11.[13]

(4) In addition to any other order of disposition, the court may order any minor included under paragraph (a) or paragraph (b) of subsection (1) of this Section, or any minor included under paragraph (c) thereof as neglected with respect to his own injurious behavior, to make restitution, in monetary or non-monetary form, under the terms and conditions of Section 5-5-6 of the "Unified Code of Corrections",[14] except that the "presentence hearing" referred to therein shall be the dispositional hearing for purposes of this Section. The parent, guardian or legal custodian of the minor may pay some or all of such restitution on the minor's behalf.

Amended by P.A. 81-845, § 2, eff. Jan. 1, 1980; P.A. 81-839, § 12, eff. Jan. 1, 1980; P.A. 81-930, § 5, eff. Jan. 1, 1980.

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705–7. Placement—Legal custody or guardianship

(f) in the case of a neglected or dependent minor under 19 years of age adjudged a ward of the court under Section 2–4 or 2–5, commit him to the Department of Children and Family Services for care and service. The Department shall be given due notice of the pendency of such action and the Guardianship Administrator of the Department of Children and Family Services shall be appointed guardian of the person of such minor. Whenever the Department discharges a minor from its care and service, the Guardianship Administrator of the Department shall petition the court for an order terminating guardianship. The Guardianship Administrator of the Department of Children and Family Services may designate one or more other officers of the Department, appointed as Department officers by administrative order of the Department Director, authorized to affix the signature of the Guardianship Administrator to documents affecting the guardian-ward relationship of children for whom he has been appointed guardian at such times as he is unable to perform the duties of his office. Such signature authorization shall include but not be limited to matters of consent of marriage, enlistment in the armed forces, legal proceedings, adoption, major medical and surgical treatment and application for driver's license. Signature authorizations made pursuant to the provisions of this paragraph shall be filed with the Secretary of State and the Secretary of State shall provide upon payment of the customary fee, certified copies of such authorization to any court or individual who requests such copy.

705–8. Reports of custodian or guardian—Change of custody

§ 5–8. Reports of custodian or guardian; change of custody. (1) The court may require any legal custodian or guardian of the person appointed under this Act to report periodically to the court or may cite him into court and require him or his agency, to make a full and accurate report of his or its doings in behalf of the minor. The custodian or guardian, within 10 days after such citation, shall make the report, either in writing verified by affidavit or orally under oath in open court, or otherwise as the court directs. Upon the hearing of the report the court may remove the custodian or guardian and appoint another in his stead or restore the minor to the custody of his parents or former guardian or custodian. However, custody of the minor shall not be restored to any parent, guardian or legal custodian in any case in which the minor is found to be neglected under Section 2–4 of this Act [1] and such neglect is found by the court under paragraph (2) of Section 4–8 of this Act [2] to be the result of physical abuse inflicted on the minor by such parent, guardian or legal custodian, until such time as an investigation is made as provided in paragraph (4) and a hearing is held on the issue of the fitness of such parent, guardian or legal custodian to care for the minor and the court enters an order that such parent, guardian or legal custodian is fit to care for the minor.

(2) A guardian or custodian appointed by the court pursuant to this Act shall file annual reports with the court. Every agency which has guardianship of a child shall file a supplemental petition for court review and further order within 24 months of dispositional order and each 24 months thereafter. Such petition shall state facts relative to the child's present condition of physical, mental and emotional health as well as facts relative to his present custodial or foster care. The petition shall be set for hearing and the clerk shall mail 10 days notice of said hearing by certified mail return receipt requested to the person or agency having the physical custody of the child, the minor and other interested parties unless a written waiver of notice is filed with said petition.

Rights of wards of the court under this Act are enforceable against any public agency by petitions for writs of mandamus filed in any proceedings brought under this Act.

707–5. State reimbursement of funds

§ 7–5. State Reimbursement of Funds. Before the 15th day of each month, the clerk of the court shall itemize all payments received by him under Section 7–4 [1] during the preceding month and shall pay such amounts to the county treasurer. Before the 20th day of each month, the county treasurer shall file with the Department of Children and Family Services an itemized statement of the amount of money for the care and shelter of a minor held in detention or shelter care or placed under Section 5–7,[2] paid by the county during the last preceding month pursuant to court order entered under Section 7–3,[3] certified by the court, and an itemized account of all payments received by the clerk of the court under Section 7–4 during the preceding month and paid over to the county treasurer, certified by the county treasurer. The Department of Children and Family Services shall examine and audit the monthly statement and account, and upon finding them correct, shall voucher for payment to the county a sum equal to the amount so paid out by the county less the amount received by the clerk of the court under Section 7–4 and paid to the county treasurer but not more than an amount equal to the current daily rate paid by the Department of Children and Family Services for regular foster care services for any minor. The amount provided for in this Amendatory Act of 1979 shall remain in effect until July 1, 1980, at which time the amount shall revert to $35 a month. Reimbursement to the counties under this Section for care and support of minors in licensed child caring institutions must be made by the Department of Children and Family Services only for care in those institutions which have filed with the Department a certificate affirming that they admit minors on the basis of need without regard to race or ethnic origin.

Amended by P.A. 81–796, § 1, eff. Sept. 16, 1979.

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CFS 101 STATE OF ILLINOIS

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

INTER-OFFICE
CORRESPONDENCE

DATE: January 22, 1981

MEMO TO: Gordon Johnson, Deputy Director, Program Operations

FROM: Frank Capler, Deputy Assistant, Program Operations

SUBJECT: Mental Health Services Issues

Attached you will find a comprehensive report which spells out the major difficulties for DCFS in accessing mental health services, both with DMH/DD psychiatric facilities and with community mental health agencies receiving grant-in-aid from that Department. To get a more comprehensive picture of our DCFS needs for such services, we have also included within this report services under contract with the above agencies as well as with other community agencies which do not have any DMH/DD funding.

The timeliness of this report cannot be overemphasized in the light of the tragic cases which you have had to review over the past several weeks. There are many operational problems involved in accessing appropriate mental health services for DCFS wards/families which have become even more critical because of the major service mandates our Department is experiencing. In addition to some of the long-range recommendations, there is an apparent need to identify operational policies at this point for our Regions in accessing such services.

I have attempted to summarize both major issues and major recommendations which will require some immediate attention.

1. Psychiatric evaluation and psychological testing services are desperately needed by our Regions, both in terms of decision making regarding maintenance of children within their own homes or their placement in substitute care programs. This is particularly significant in those cases where there is suspected mental health pathology or mental health crisis issues affecting the stability of families.

2. While counseling services are being provided, many of the agencies have unusual difficulties in addressing the so-called "child psychiatric services" and often many community agencies are unable to provide relevant services to adolescents in crisis.

3. While some services are being provided, the trend has been to exclude from such services children under DCFS guardianship since many agencies require that services be based on a voluntary basis.

4. The agreements arrived at between the two Departments apparently have never been shared adequately with community mental health providers who generally belong to the Illinois Association of Community Mental Health Agencies.* Indeed our Regions express much confusion in their interpretation of these basic agreements with respect to those services which should be rendered "free of charge" and those services which should be secured under DCFS POS contracts. In short, these agreements need to be reviewed and updated with particular reference to the service mandates of this Department and the critical needs for a relevant mental health service delivery system. This dilemma is particularly imperative for resolution since this Department has been moving from the provision of direct services by DCFS staff to services contracted with a variety of community agencies.

5. There is a lack of uniformity in addressing the issue of specialized contracts with DMH/DD grant-in-aid agencies and frequently DCFS has erected a service delivery system with non-DMH/DD funded agencies. This practive may, in effect, jeopardize the intent of the Bureau of the Budget and certainly has a profound implication in the area of cost containment.

6. In addressing the point above, it should be noted that a high priority for this Department is programmatic review of any agency under contract to provide direct services. At the Deputy Assistants' meeting on 1/21/81, it was pointed out that this Department lacks a uniform consistent program review process. Contracts may be written without such a review and may be renegotiated without an adequate review. If this Department firmly believes that its service mandate is best carried out through contractual arrangements with community agencies, it appears particularly imperative to have an adequate instrument for evaluating programmatic effectiveness.

7. DCFS Regions are having an extremely difficult time in securing appropriate residential care by DMH/DD facilities for those youngsters who are unmanageable either in our residential facilities or in other alternative modes of substitute care. At the same time DMH/DD is under severe constraints to admit only those youngsters who are deemed in serious risk of psychiatirc hospitalization because of imminent harm to themselves or to others or profound inability to care for themselves. There are severe deficits in attempting to provide a suitable service delivery system between the Departments and other community agencies for this population and that need must be addressed.

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*Amplification of this information is in the Commission on Children Office.

While there are other problems expressed within the report, the major issues noted above are suggestive of the following recommendations:

1. The Regions need to secure general service agreements with the mental health centers regardless of the funding difficulties involved. Many Regions indicate a lack of awareness of the structure, organization or service mandates of these centers. That issue needs to be addressed at the local field office level if possible.

2. Each Region should have a "lead person" to work with the appropriate DMH/DD Regional/Subregional Coordinators assigned the monitoring and technical assistance responsibilities with community grant-in-aid mental health agencies. This is particularly important in terms of developing adequate working relationships. In this regard it should be noted that mental health centers have governing boards of directors who represent the major communities within their service area. There is no reason why our own Regional Advisory Councils cannot help to facilitate such a process.

3. DCFS needs to reassess its POS counseling line and establish uniform guidelines with the Regions in contracting for community based counseling services.

4. DCFS, DMH/DD, community mental health centers under grant-in-aid, DPA should all develop a working task force to explore the needs of DCFS wards-families and the appropriate type and level of service. Funding issues may necessarily involve all of these groups as well as the "Bureau of the Budget". As you know, the Governor's Youth Initiative was designed to deal with those cases which seemed to cross various Departmental mandates. Much of this population has not been serviced adequately, even under the existing policy framework between the Departments.

5. In addition to some of the long-range problems and recommendations noted above, several Regions have requested some immediate guidelines to deal with the following problems:

   a. When a court orders both an evaluation and a commitment from a Region to pay the bill which in some instances approximates $250.00, under what line is such payment made and can such a payment be made?

   b. Some Regions have indicated that they are being billed for those services by community mental health agencies which the Region understood to be "free of charge" under the current policies. While the Regions may decline such payments, it is inefficient to tie up Regional staff and time in responding to those billings.

Gordon Johnson January 22, 1981

c. Some Regions have indicated a need to have a specific policy enforced for those kinds of services that they can legitimately contract. This seems important since we are currently in the budgetary cycle.

The above highlights some of the major concerns and some of the recommendations which may be helpful to you. I would be most happy to discuss the comprehensive report in more detail with you and with Kenley Wade at your earliest convenience.

Attachment

cc: Kenley Wade

FC/pb

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SECTION I

HISTORICAL PERSPECTIVE

"Mental Health Services and DCFS"

A. Introduction

To understand the issues, problems and recommendations contained in this Report surrounding DCFS access to Mental Health Services from DMH-DD and its community mental health agencies receiving Grant-in-Aid, this Section investigates those factors within each group (DMH-DD, Community Mental Health Agencies, and DCFS) which have a bearing on the current status of services. Policy statements, still operational, are examined in some detail, since they define both service and collaborative efforts among the major participants and provide the starting point for needed updating and progressive changes.

B. Community Mental Health Services and DMH-DD

During President John Kennedy's administration, major steps were taken to develop Comprehensive Community Mental Health Centers throughout the nation. The impetus for this movement was two-fold: (1) to reduce or eliminate the widespread "warehousing" and "institutionalizing" of adults, adolescents and children in giant State and Federal psychiatric hospitals throughout the country, and (2) to establish comprehensive community-based mental health services easily accessible to all communities. Gnerally speaking, such community mental health centers were expected to provide an array of services which included emergency 24-hour services; screening programs for psychiatric in-patient services; partial hospitalization (Day Treatment) and Aftercare Services; out-patient services including medication follow-up and counseling programs; and community education/consultation services. Services could not be declined because of race, creed, origins or income levels.

To assist in the development and implementation of the community mental health services program, the Federal Government (NIMH) developed Regional Centers to work with the various States. These Regional Centers provided major program consultation and a variety of funding mechanisms, largely through Federal Compact arrangements under the National Institute of Mental Health. Compacts permitted smaller geographic areas to integrate program resources under 5-year and 7-year plans in which original funding by the Federal Government at a 100% level would decline proportionately as State and local base funding increased. In other words, Federal funding was primarily intended as a "seed operation" and as more and more patients left State Hospitals and these facilities were decreased in size or eliminated all together, additional state monies could be freed up for additional funding revenues for community mental health agencies. In addition, a further major expectation was the financial participation by counties, United Way and other community funding sources.

Here in Illinois, there was a dramatic reduction in the population of our State Hospitals during the 1960's and 1970's and a proliferation of community-based mental health services has taken place. While many community providers have felt that the flow of patients back into the community has not been accompanied by a proportionate share of State dollars supporting dwindling State institutions, many centers receive some grant-in-aid funding by the Department of Mental Health and Developmental Disabilities, some support by United Way funding and other community fund raising efforts, and funding through County Board participation. Many agencies belong to and are governed by 708 Boards or Public Health Boards. All centers receiving grant-in-aid funding by DMH-DD are expected to also raise revenue by outside contracts and sliding fee scale arrangements approved by DMH-DD. Grant-in-aid funding declines proportionately as community mental health agencies develop other funding alternatives.

Over the past few years, vested interest groups have lobbied across the State for specialized drug programs, alcoholism services, highly expensive programs in mental retardation and other developmental disabilities. The administrative costs in partializing and specializing services has been tremendous and the competition for dollars has been frantic.

At the same time, community mental health agencies have received even tighter service mandates by DMH-DD to screen all admissions to State psychiatric and developmental disabilities programs and to other community-based facilities receiving funding assistance by the Department. That mandate means reducing first time admissions and substantially reducing the recidivism rate or readmissions to State facilities. In addition, other services must be directed primarily to what the Department views as high risk target populations: the psychotics, persons in danger of suicide or posing severe harm to others, etc. A major target group as a priority for community mental health agencies are those persons discharged from State facilities requiring after care services. Yet as community based programs seek local funding resources, the community itself may have other kinds of service mandates it considers crucial and these agencies have to be responsive to those needs as well.

These various mandates pose additional resource development issues as well. Staff recruitment efforts may be hampered by the fact that salary levels for community mental health agency personnel are well below salary levels for their counterparts in State service. This is particularly true in the case of personnel other than psychiatrists or Ph.D. psychologists. In terms of psychiatrists and Ph.D. psychologists, most mental health centers simply cannot afford to hire them on a full-time basis, and part-time costs may average $40 to $60 per hour.

All of the above factors are critically important in addressing mental health service issues raised by our DCFS Regions in their efforts to access mental health services for our clients and families. For mental health centers, our wards and families are but a portion of their own target population. Both in the Rockford and Springfield Regions, discussions with community mental health agency directors indicates a willingness or general acceptance of the need for services for DCFS clients but the difficulty of scant resources, both fiscal and personnel, in doing so.

C. DCFS and Child Welfare Services

Paralleling the growth in community mental health programs, the steady decline in State Hospital populations, and the primary focus by DMH-DD in narrowing services to the most serious emotionally disturbed developmentally disabled clients, has been the ever expanding mandates for DCFS and the Child Welfare field itself. DCFS is currently experiencing increased mandates for permanency planning, for reduction in institutional, group home and foster home placements, and for a wide range of in-home services. In addition to this kind of focus, the current Child Abuse/Neglect Reporting law and the major thrust in developing a responsive Child Abuse/Neglect Investigation System and follow-up process increases the Department's concern for accessing appropriate mental health services. Family pathology and often community based pathology play havoc with the safe, nurturing, family-based environment viewed as terribly crucial in the healthy development of children. The Department itself has moved dramatically from the provision of direct services to the purchase of service concept, and as line staff move from direct service intervention to "decision makers", the search for relevant, responsive communitybased services emerges as a top priority for the Department.

Decision-making, in the truest professional sense, has far reaching consequences for our clients and for the Department itself. Permanency planning options for children, often defenseless, may demand the most skilled psychiatric/psychological evaluation to ensure that a youngster may be maintained safely in the natural home, or to ensure that any placement option is in the best interest of the child, or to map out a strategy of treatment and decision making to allow the child to return home. In addition to these "humane considerations", DCFS also has ever tightening budgetary constraints which demand that the Department focus on cost containment. Both issues are not necessarily dramatically opposed if all decision-making and treatment options can be exercised.

D. Policy Statements

Within this context, the partnership between DCFS and community mental health agencies requires positive analysis and evaluation. Historically, our child welfare mandate and their mental health mandate, often exercised with respect to the same target populations, led to the adoption of general agreements between DMH-DD and DCFS which must be understood if service barriers are to bridged and a new era of partnership developed.

On September 30, 1974, Dr. LeRoy F. Leavitt, then Director of the Department of Mental Health and Developmental Disabilities sent a Policy Memorandum, shared with Mrs. Mary Lee Leahy, then Director of DCFS, to all Grant-in-Aid recipients - FY 1975 in which he stated that DMH-DD has noted that wards of DCFS may at times need treatment in community mental health facilities, that these wards are considered as "high risk clients and indigents" and that "services provided by 'your agency' will be made available to wards of DCFS free-of-charge".

This Policy Memorandum was also apparently sent out to our DCFS Area offices throughout the State and has been the basis under which DCFS has operated with community mental health agencies. However, on June 19, 1975 and July 7, 1975, two additional Policy Memoranda were sent out to Grant-in-Aid agencies by Dr. Leavitt clarifying and narrowing the scope of the broad service mandate for community mental health agencies in serving DCFS wards and families as enunciated in the original Policy Memorandum of September 30, 1974. It is questionable if these additional policy statements were seen by DCFS Area offices and field offices, and this factor may have precipitated some of the confusion and "bad feelings" which exist today.

These two documents raised the issue of distinguishing "general child welfare services" from "mental or psychiatric services" needed by DCFS wards and their families. Mental health, or psychiatric services, are to be extended "free of charge" to those children and adolescents "who need treatment primarily for psychiatric problems and who are in high risk of hospitalization".

General child welfare services, on the other hand, may be extended by DMH-DD funded community mental health agencies under POS contracts with DCFS or other community funding sources. Such services were grouped into eight areas and cover many of the usual reasons for DCFS referrals. These two documents are included in Appendix A and should be referred to for specific types of services viewed by Dr. Leavitt as "general welfare services". DCFS currently purchases many of these services under POS contracts with non-DMH-DD agencies!!

Dr. Leavitt also wrote a separate memo of June 16, 1975 to Director Leahy noting that his original Policy Memorandum of September 30, 1974 required further clarification because of issues raised by some community agencies supported by DMH-DD funding which also traditionally provided family and social services as well as mental health services. The Illinois Association of Community Mental Health Agencies (IACMHA), DMH-DD Region 2 staff and DCFS Area office personnel and various community agencies met together and made a number of recommendations delineating generic child welfare services versus mental health services to DCFS wards. Those recommendations were incorporated into his subsequent memos noted above. Dr. Leavitt also expressed, in his July 7, 1975 Policy Memorandum the need for Region/Subregion staff of DMH-DD, community agency staff, and DCFS to review the types of services needed by DCFS wards and the appropriate determination of mental health services required. He ends this last memo with the following words:

> "In order for the combined resources of the two Departments and the community to be maximized for the benefit of strengthening individual and family life, the highest degree of commitment, cooperation and creativity of department and community staff must be assured".

Despite the obvious efforts to develop a close, collaborative working relationship between the two Departments, the major demarcation of general child welfare services and mental health services continues to plague everyone. No formal working procedures were ever drafted and these are necessary for meeting the intent of policy declarations. On June 1, 1975, the two Departments drafted a formal agreement in mutually working with DCFS wards who were developmentally disabled. This agreement, designed to promote DMH-DD assistance to DCFS in programming and placement monitoring for this population requiring a residential setting, was accompanied by defined operating procedures worked out by the two Departments. (The Agreement and Procedures are included in Appendix A.) No such procedures were developed by DMH-DD, DCFS and DMH-DD funded mental health agencies - indeed, a number of these agencies maintain that their governing bodies had never been involved in negotiations between the two Departments. Furthermore, the Grant-in-Aid contracts between DMH-DD and community agencies do not specifically cover services to DCFS wards and families and no mention of the Policy Memoranda, noted above, are cited in these contracts.

While a number of the community mental health agencies feel that their services are appropriate for DCFS wards/families, the basic issue continues to be one of funding and staffing resources. This issue needs to be examined more realistically by DCFS, DMH-DD, DPA, IACMHA, and the Bureau of the Budget.

E. Further Service Constraints

Before passing on to other Sections of this Report, one additional issue, frequently cited in Regional Reports, requires additional historicaly perspective. Regions report considerable difficulty in securing DMH-DD residential placement for wards experiencing "mental or emotional illness" or "developmental disabilities problems". For DCFS, staff may often feel that major behavioral disruption, often initiating the court ordered referral, necessitates residential psychiatric treatment only to have the referral declined by the DMH-DD facility. The ward cannot be maintained in the home, DCFS is unable to utilize any of its own placement resources, and the DCFS worker strongly feels that emotional pathology underlies the behavioral problem.

Aside from the many diagnostic issues currently fracturing the mental health field, DMH-DD has, over the past several years, been subject to ever tighter controls in accepting admissions into its State-operated facilities. Federal and State legislation, Civil Rights Actions, as well as a number of court ordered policies, particularly by Judge Schneider, have demanded that residential placements within State-operated facilities can only be utilized as a "last resort" and never on an "undetermined time basis". "Mental illness", requiring psychiatric hospitalization generally means that the person, based on extensive examination, is found to be "psychotic" or so emotionally disturbed that he/she may seriously harm himself/herself or others, or is rendered incapable of caring for self. DMH-DD now demands that all referrals for in-patient hospitalization must be initially screened by the appropriate community Grant-in-Aid mental health agency. In addition, some State-operated facilities have also established screening committees and case review committees which some DCFS regions have identified as duplicative and excessively time consuming.

It should be noted that DCFS, itself, is also experiencing tighter controls in placement of children outside of their own homes. Permanency planning, least restrictive environment, and other progressive concepts are finding their place in legislation, policy statements and defined procedural development. In the past, both DMH-DD and DCFS have been critically castigated by Judge Schneider and other courts regarding their placement process.

In the light of the above discussion, it seems more important and urgent that DCFS, DMH-DD and the Illinois Associate of Community Mental Health Agencies address the serious programmatic issues of relevant services to identified target populations of DCFS wards.

SECTION II

CURRENT ISSUES AND RECOMMENDATIONS

In this Section, major service and programmatic issues detailed in the Regional Reports are summarized. Various resolution recommendations are proposed which seek to promote uniform awareness of current policies in force, areas for further negotiations, policy updates. and operational guidelines designed to promote greater service efficiency between all active participants.

Issue #1

Regions appear to lack a clear uniform understanding of those Policy Memoranda, currently in force, which spell out those services which should be rendered "free of charge" to DCFS wards, and those services which can be provided to DCFS wards/families by DMH-DD Grant-in-Aid community mental health agencies through POS contracts. This issue might be addressed at a Regional Administrators' Meeting by Central Office and a representative of DMH-DD. Contracting Guidelines should be addressed.

Issue #2

While mental health centers are rendering some "mental health services", Regions have reported the following problems:

1. Psychiatric/Psychological Evaluations: All Regions report varying problems in accessing these services through community mental health agencies. Current policies limit those services ("free of charge") to those DCFS wards experiencing serious psychiatric problems and in danger of psychiatric hospitalization. These services are not "free of charge" for general placement evaluations in DCFS residential group home or foster homes. However, in effecting such evaluations for "general child welfare services", DCFS can establish POS contracts, and/or in addition these services can be reimbursed to mental health centers through DPA green cards. This latter practice should be reviewed by DCFS Regions with their community mental health providers and DPA area offices. It might also help if DCFS staff screen their referrals to ascertain if families have insurance benefits to cover professional psychiatric/psychological services and at least indicate that to the mental health provider.

   Third party vendor payments can be made to both groups, and mental health centers often have contracts with these professionals where these monies accrue to the agency to offset budget costs for retaining these staff. Further attention to such detail may permit the mental health centers to expand such resources to better meet the volume of referrals from DCFS and to more adeptly specialize in the area of child psychiatric services.

Many Regions noted that mental health agency staff do not always have the necessary expertise in child psychiatry and in the area of adolescent services. That kind of specialization is often quite costly and funding issues are critical. The Policy Memoranda noted earlier were designed to effectively utilize the resources of both Departments in expanding the service capability of community mental health centers in meeting the mental health needs of DCFS wards and their families. Because of our own greatly expanded child welfare mandates, those needs will continue to escalate.

In practice, Regions may contract for such services with other mental health professionals, with medical schools, or with other private agencies and hospitals which have psychiatric programs. Yet a number of Regions have felt that community mental health agencies, with DMH-DD Grant-in-Aid could probably provide the same services at less cost and within less extended time frames. In actuality, to some extent both Departments may have engaged in the costly practice of funding duplicative community services without sufficient attention to the integrative intent of Policy Memoranda drafted in 1974 and 1975. Grant-in-Aid funding, along with DCFS POS contracts with mental health providers, were clearly indicated but that has not always been the case.

2. Access to Counseling Services: Within the past several years, DCFS has dramatically moved from the provision of direct services, including counseling, to the purchase of service agreements with community-based agencies. In those cases where suspected mental health pathology underlies family child rearing deficits or behavioral deficits of wards, and threatens the maintenance of children within their natural homes, the need for responsive mental health counseling is obvious. With respect to such services by DMH-DD Grant-in-Aid mental health agencies, DCFS Regions have noted the following problems:

   (a) Intake and assignment of counseling staff often take considerable time, particularly for those cases extended "free of charge" to DCFS. Regions with specialized POS contracts with these agencies generally feel that DCFS clients are more quickly and efficiently serviced.

   (b) Some Regions indicate a feeling that counseling and diagnostic services by these centers are geared toward adult populations rather than for children and adolescents. Again, the issue of specialized child psychiatric programs emerges as a high priority.

   (c) Lack of integrated family therapy programs has been cited as a deficit, particularly for those DCFS cases requiring in-home intervention to prevent placements and to ensure permanency planning options.

(d) Mental health agencies generally expect clients to participate in counseling and other direct services on a "voluntary basis". The fact that DCFS may have "guardianship rights" over referred wards is often construed as indicating non-voluntary participation. Yet there is really little difference between services for children secured by natural parents and services secured for children through DCFS guardianship, at least as far as "voluntary participation" applies. In the final analysis, all therapeutic relationships have the task of enlisting the cooperative efforts of both client and therapist in the achievement of mutually acceptable therapeutic goals.

(e) Several DCFS Regions have identified the lack of outreach programs by mental health centers as a serious deficit. As in the issue of voluntary participation, many DCFS clients may have poor motivation, anxiety about seeking "mental health" services, transportation difficulties, inability or unwillingness to pay fees, and a host of other coping problems. DCFS staff express the need for mental health agencies to more aggressively follow-up missed opportunities and/or to offer services in a more realistic fashion with evening or weekend appointments, particularly to accommodate student hours and working parents. At the same time, both DCFS staff and mental health agency staff need to work collaboratively together in securing active client cooperation.

Issue #3

Other programmatic and service related problems are:

1. Both administrative structures and service programs of community mental health agencies within the boundaries of a DCFS Region may vary greatly and pose unique problems with respect to inter-agency agreements with local DCFS Field Offices. Some Regions do not have any formal general service agreements with DMH-DD Grant-in-Aid agencies.

2. Regions and Field Offices may have little recognition or awareness of personnel and programmatic capacity of local mental health centers, particularly with respect to psychiatric/psychological staff. At the same time, mental health agencies may not always be aware of resources, staffing constraints, and program shifts within the DCFS system.

3. DCFS Regions report major problems in securing admissions of wards into DMH-DD facilities for the mentally ill and the developmentally disabled. Some of the problems are related to the general material covered under Section I of this Report. As noted earlier, community mental health agencies are first echelon screening facilities for DMH-DD residential referrals. Within the DMH-DD network, second echelon services are community hospitals with psychiatric

in-patient facilities. DMH-DD residential facilities constitute 3rd echelon services. As the initial screening facility, community mental health agencies provide the required liaison functions with 2nd and 3rd echelon facilities both for admission purposes and for required aftercare services for patients discharged into the community. Some Regions report that some mental health centers refer DCFS staff directly to hospital and/or habilitation residential facilities while in other instances, the mental health center may do the screening only to have an additional screening demanded by DMH-DD facilities.

4. Lack of investitute in outcome goals by both DMH-DD and DMH-DD Grant-in-Aid mental health centers as related to the DCFS mandate to prevent placement of children, whenever possible, is another major concern expressed by our Regions. Yet in many ways, this particular mandate, with its emphasis on permanency planning, is identical for both Departments with respect to their own service populations. The major issue still remains regarding personnel and program development resources available at the local community level, not only for the prevention of unnecessary placements but more importantly in the establishment of sound, meaningful programs designed to maintain families intact.

5. Interim Care Grants, designed by DMH-DD for providing temporary residential care in non-DMH-DD facilities for children and adolescents requiring structured settings with mental health services, are extremely difficult to get according to our Regions. For those children and adolescents denied admissions into DMH-DD facilities, and denied DMH-DD Interim Care Grants, DCFS frequently places them in other kinds of child welfare residential programs with psychiatric consultation/counseling services. In some instances, such placements have been made for the primary purpose of obtaining mental health services. Some Regions have recommended joint funding by DMH-DD and DCFS of those placements requiring both mental health services and general child welfare services. It should be noted that a significant number of Voluntary Placement Agreement extention requests cite continued residential placement so that psychiatric treatment can be completed. If that is the primary reason for continued placement, certainly DMH-DD must share some responsibility.

6. Some Regions have identified referrals made to DCFS Field Offices by community mental health agencies for placement of children to reduce family stress during therapy. In commenting on this practice, placement requests have been made when there does not appear to be any risk of harm to children. Just as DMH-DD seeks to limit in-patient psychiatric hospitalization only to those cases requiring such care, DCFS must also limit its placement of children in substitute care to those cases requiring such care because of urgent child welfare problems.

Other General Recommendations

1. DCFS Regions should identify a "lead person" to work with the appropriate DMH-DD Regional/Sub-regional coordinator assigned monitoring and technical assistance responsibilities with community Grant-in-Aid mental Health agencies within the DCFS Region. Since local mental health agencies under contract with DMH-DD have their own local governing Boards of Directors, the utilization of DMH-DD Sub-regional coordinators can be helpful. Major emphasis should be placed on the following:

   (a) To develop general service agreements between DCFS Field Offices and local mental health centers within their catchment area, within a general framework developed at the Regional level.

   (b) Discussion and resolution of specific case problems and identification of appropriate services as outlined in Dr. Leavitt's Policy Memoranda.

   (c) On-going identification of programmatic needs in both sectors for planning and problem resolution at Regional and Central Office level.

2. DCFS needs to reassess its POS counseling line and establish uniform guidelines with the Regions in contracting for community-based counseling services. Some Regions have established contracts with DMH-DD Grant-in-Aid mental health agencies (Champaign, East St. Louis, Marion and Peoria) totalling approximately $383,100. East St. Louis Region also utilizes approximately $3,724.92 in Staff Development Funds to contract training programs for staff and Foster Parent Programs.

   Regions providing fiscal data for POS counseling contracts with non-DMH-DD funded agencies estimate total expenditures at $5,713,039 ($3.3 million in Chicago).

   Such guidelines will require factual data from the Regions which should include a review of the staffing and programmatic resources of local community mental health centers with DMH-DD Grant-in-Aid, the rationale and costs for contracting with other agency providers and mental health professionals, and a clearer delineation of case projections for mental health services. One problem has been that for referrals for services expected to be provided "free of charge", frequently no data is kept by most of the Regions.

3. Further planning and negotiations need to take place, at least initially, between the 3 major groups: DMH-DD, DCFS and the Illinois Association of Community Mental Health Agencies. Such negotiations need to focus on the overall mental health needs of DCFS wards/families, the role of each group, the fiscal and programmatic resources required, and appropriate funding mechanisms to get the job

accomplished. The task should be accomplished over the next six months. Most likely there should be further discussions with DPA for services covered under the green card and with the Bureau of the Budget.

SECTION III

REGIONAL SUMMARY DATA

I. Introduction

This Section will summarize the ways in which Regions are currently attempting to secure mental health services for DCFS wards/families. In reviewing this data, several factors need to be taken into account.

1. Referrals to DMH-DD Grant-in-Aid mental health centers for services "free of charge", i.e. without POS contracts, are generally not logged and, for the most part, may be estimated.

2. Some Regions were unable to provide all the data requested in the Survey Memo from Gordon Johnson, dated October 15, 1980. However, the Reports do see to indicate general trends even for those Regions who did not provide comprehensive data.

3. Most problem or issue areas indicated by the various Regions have been summarized under Section II. Unique problems to a Region are included within this Section where applicable.

II. General Summary of Regional Data

A. Aurora

1. Referrals to DMH-DD Grant-in-Aid agencies without POS contracts - none reported.

2. The Region does not have any POS contracts with these agencies.

3. Referrals to other community agencies with POS contracts - 1,082 clients/families at a total expenditure of $1,546,321.

Comments: The Region submitted a listing by agency and contract expenditure of all its POS contracts for counseling services. The Region has major difficulty in seeking mental health services for "older kids", particularly for young adults 19-20. DMH-DD lacks "outreach services" and "lacks in accepting referrals for DD children".

B. Champaign Region

1. Referrals made, or which could be made to DMH-DD funded CMHC's without POS contracts are given as follows:

Psychiatric evaluations - 198/year
Psychological evaluations - 228/year
Counseling services - 516/year
Day treatment/rehabilitation - 84/year
Medication follow-up - 108/year
Other - 126/year
Total volume of referrals - 1,260

2. POS contracts with DMH-DD mental health agencies totaled $100,059 for services to 220 clients/ families per year.

3. POS contracts with other community agencies totaled $67,053 with services to 196 clients/ families.

C. Chicago Region

The following data was obtained verbally by phone from Area Offices and Resource Development Units. At best, it represents "guess-estimates".

1. East Area Office reports 50 families and 101 children referred to local mental health centers during the past year. 17 parents and 87 children were referred for counseling services to other non-DMH-DD agencies during the same period. The Resource Development Supervisor also called and reported 60 clients referred for psychological evaluation and 250 counseling referrals. The two sets of statistics are confusing but are given as reported.

Comments: Staff have been encouraged to utilize DMH-DD funded community mental health centers which are often "untapped and underutilized". POS contracts with oter agencies are extremely costly and often services are unnecessarily prolonged.

2. Chicago South reported 20 clients referred for psychiatric evaluation; 34 clients referred for psychological evaluation; and approximately 73 clients referred for counseling services.

Comments: Psychiatric/psychological evaluations are extremely difficult to secure through DMH-DD funded agencies; counseling services are somewhat easier to secure from these agencies. The Area Office relies more extensively on the City of Chicago mental health programs. It also utilizes both private hospitals with psychiatric programs, and DMH-DD facilities although most referrals to these facilities are for inpatient hospitalization.

3. North Area Office - the Resource Development Supervisor states that no referrals have been made to DMH-DD funded community mental health agencies for

psychiatric/psychological evaluations since these services are provided through court programs. For counseling services, the Area Office refers clients primarily to non-DMH-DD funded agencies under POS contracts (like the Evanston Family Service Agency). Approximately 24 clients were referred to DMH-DD funded agencies for counseling and an additional 4 clients were referred for medication follow-up.

4. West Area Office reports that DMH-DD funded community mental health agencies are seldom used for psychiatric/psychological evaluations since such services are not easily available. However, counseling referrals to these agencies are "moderately high". No formal statistics were available because of vacation schedules and the lack of lead time. The Area Office also relies on POS contracts with other non-DMH-DD community agencies for evaluation and counseling services.

Comments:

1. According to Charles Johnson, Contracts/Grants Administrator, the Chicago Region has no POS contracts with DMH-DD Grant-in-Aid community mental health centers. They do have contracts with DMH-DD facilities like Lt. Joseph P. Kennedy and Lee Cunningham Programs. The Region has approximately $3.3 million in POS contracts with other non-DMH-DD agencies and the bulk of mental health services referrals (primarily for counseling) are made to these agencies.

2. The closure of Elgin and Tinley Park residential programs for emotionally disturbed children/ adolescents, and the closure of one DMH-DD facility for developmentally disabled children have made it extremely difficult to secure alternative resources for these target populations.

3. DMH-DD Grant-in-Aid community mental health centers seldom have "outreach" programs and are largely based on "medical model" approach with difficult access-related problems for DCFS wards/families. Consequently, the Region must rely heavily on POS contracts with other community agencies.

4. CPS Unit referred cases to DMH-DD Grant-in-Aid mental health centers were not studied and no figures were obtained. However, Regions generally report that referrals are often made at the point of intake to assess child abuse/neglect cases and the maintenance of intact families, so this kind of data might be helpful for the Chicago Region as well.

D. East St. Louis Region

1. Referrals to DMH-DD Grant-in-Aid mental health agencies - 344 on an annualized basis.

2. POS contracts with three community mental health providers (under DFI Funds) have been established to provide "parenting services" designed to prevent and/or remedy neglect and abuse. These contracts, totaling $38,473, provide services to approximately 68 families.

3. The Region also has 2 POS contracts with DMH-DD Grant-in-Aid agencies through Staff Development Funds, in the amount of $3,724 to provide mental health orientation for 100 DCFS direct service staff and for Foster Parent training.

4. The Region has no other POS contracts with other non-DMH-DD agencies for mental health services.

5. The Region has been able to refer clients to private psychiatrists willing to provide services under the green card.

Comments: The Region has developed on-going service agreements with 9 DMH-DD community mental health centers. Enclosed in the Regional Report are two such contracts which could serve as a basis for other Regions in writing general service agreements as suggested in Section II.* The Region emphasizes the need for more outreach programs, particularly for adolescents. The Region generally has been able to access services and has illustrated the collaborative work of DCFS and agency staff in jointly developing programs. Communication between staffs is quite good and lends itself to problem resolution.

E. Marion Region

1. Referrals to DMH-DD Grant-in-Aid agencies without POS contracts are summarized in the following categories:

Psychiatric evaluations - 10 year
Psychological evaluations - 60 per year
Counseling services - 110 clients/families per month or 1,320 per year
Day treatment/rehabilitation - 120 year

2. Under POS contracts with DMH-DD funded providers, anticipated services will cost $184,435 for approximately 202 clients. These contracts cover Youth Advocacy, Stress Challenge, UM Counseling (DFI) and Family Counseling services.

*Amplification of this information is in the Commission on

3. Under POS contracts with non-DMH-DD funded agencies, the Region will spend $629,902 during FY '81 with services to approximately 283 clients. These contracts cover Family Counseling, UM Counseling (DFI), Developmentally Disabled Youth Counseling and Family Counseling Services (DFI). The contracts offer wider treatment modalities to DCFS clients/families than the "traditional mental health model", particularly in the area of outreach services to "involuntary clients".

Comment:

1. The Region could expand its referrals for psychiatric/psychological evaluations with DMH-DD Grant-in-Aid providers if these programs had greater capability. The Region has had to rely on other sources such as the clinic at Southern Illinois University, or POS contracts with other agencies. The Region suggests that DMH-DD providers develop specialized and qualified diagnostic teams on a "special education district" approach.

2. The Region has special difficulty in referring cases for "institutionalization" because of the duplicative screening process with DMH-DD providers and State facilities.

3. The Region strongly feels that DMH-DD Grant-in-Aid agencies need to develop outreach, home intervention work with involuntary clients and authority based counseling. Because of these deficits, the Region has had to develop other POS contracts which "fosters a duplicative delivery system at taxpayer expense and relieves the local clinics of their responsibility".

4. Confidentiality issues need to be resolved between DMH-DD, DCFS and DMH-DD funded community providers.

5. Some local DMH-DD Grant-in-Aid agencies "bill for services not applicable to POS contracts" and while they may not expect payment, replies by the Regional Office are time consuming. Policy guidelines are needed.

F. Peoria Region

1. Approximately 75 clients were referred to DMH-DD Grant-in-Aid mental health centers for services not covered by POS contracts. Some Field Offices did not submit statistics.

2. Under POS contracts with DMH-DD funded agencies, the Region has allocated $60,133 for services to 122 clients. In addition, the Region has contracts with two mental health professionals in the amount of $18,500 for services to 21 clients.

3. Under POS contracts with non-DMH-DD agencies, the Region is expending $25,000 for services to approximately 80 clients. These services are primarily diagnostic in nature which the Region feels should be rendered by DMH-DD Grant-in-Aid agencies. One additional agency was cited without dollar allocation or clients served.

Comments:

1. Psychiatric services in some areas are not available through any of their mental health facilities and are characterized by the absence of children's programs. Counseling services may be extended but generally only through POS contracts.

2. The Region has had great difficulty in securing DMH-DD Interim Care Grants and has submitted a letter from DMH-DD Assistant Regional Administrator, in effect relieving DMH-DD of nearly any responsibility in that matter.

3. Evening and after hour appointments are needed to service working parents and children with after school jobs.

4. Outreach services are needed for both intake and ongoing case situations.

5. Short-term in-patient programs are also needed.

G. Rockford Region

1. Estimated annual referrals to DMH-DD Grant-in-Aid Community Mental Health Centers for specific services are as follows:

Psychiatric/Psychological Evaluations	438
Counseling Services	1,148
Day Treatment/Rehabilitation	4

The Rock Falls Field Office noted it could project an additional 200 referrals for psychiatric evaluation and an additional 125 referrals for "risk assessments".

2. The Region does not have any POS contracts with DMH-DD Grant-in-Aid Agencies. One such contract did exist, but the key issue has been delineating what DCFS should purchase versus services normally provided under DMH-DD Grant-in-Aid funding.

3. The Region has referred 29 clients to non-DMH-DD funded agencies. No data or dollar amounts for these POS contracts were submitted. One private psychologist is under contract with the Freeport Field Office to whom four children have been referred for evaluation at the rate of $25 per workup.

NOTE: This contrasts dramatically with the charges for similar services, e.g., in the Springfield Region, which may run from $60 to $250.

Comments:

1. Access to Mental Health Centers varies across the Region, particularly with respect to Outreach programs. In the Rock Falls Field Office area, a minimum of one-third of all DCFS clients have no means of transportation to the Sinissippi Mental Health Center. Programmatic resources for specialized target groups are scanty. Principal issues have been included in Section II of this Report as well as other issues noted by the Region which were similar to other Region comments.

H. Springfield Region

1. The Springfield Region has referred approximately 714 clients/families to local DMH-DD funded Mental Health Centers during the last year. Approximately 72 referrals were for psychiatric evaluations; 70 for psychological evaluations; 476 for counseling services; 41 for medication follow-up; 15 for screening evaluation for in-patient hospiatlization; and 5 for Day Treatment/Rehabilitation services. Among some of the problems experienced by the Region in accessing Mental Health services has been the availability of evening hours appointments for working patients, emergency telephone coverages after hours, on weekends and holidays in most of the smaller communities. Services for disturbed acting-out adolescents are hard to come by and the screening process for placement in DMH-DD facilities has been extremely difficult.

NOTE: For the most part, services have been provided to DCFS Wards and families. At the current time, the Region is experiencing serious service delivery problems in Sangamon County with the Springfield Mental Health Center. In a way, the emerging issues have special significance since their resolution with this Center may have Statewide implications as a "trial case". Both DMH-DD and IACMHA-the Illinois Association of Community Mental Health Agencies are quite aware of the current local situation.

2. The Region currently has no POS contracts with any DMH-DD funded Community Mental Health Agency. A Child Abuse Grant had been awarded to one such agency, but was cancelled at their request on September 30, 1980. This program had been servicing 25 families, cost not noted.

3. Mental Health Services offered, under POS contracts, by other non-DMH-DD Grant-in-Aid agencies and/or Mental Health Professionals indicate a cost of $144,763 for services to 970 clients/families. Parents Anonymous of Springfield accounted for counseling services to 600 clients at a cost of $31,680!! These contracts were developed because of the expertise and interest of the providers in addressing the particular needs of the target population to be served.

III. STATEWIDE TOTALS: REFERRALS AND/OR EXPENDITURES MENTAL HEALTH SERVICES

Below is a summary of the totals as provided by the regions. The data may not be complete since not every region responded in the same way. Also, the problem of accurate referral data, particularly for services provided by DMH-DD Grant-in-Aid Agencies without resort to DCFS POS Contracts, must be taken into account since such referrals are not generally logged. However, sufficient data is at least available to indicate the trends, statewide, in regional based attempts to gain access to needed mental health services.

	Referrals	Expenditures
DMH-DD Grant-in-Aid Agencies without POS Contracts	4,899	-0-
DMH-DD Grant-in-Aid Agencies under POS Contracts for services N.B. E. St. Louis Region also has 2 additional contracts in the amount of $3,724 to provide mental health orientation to 100 Direct Service Workers and for Foster Parent Training Programs.	612	$383,100
Other Private Agencies with POS Contracts N.B. Of the reported expenditure total, the Chicago Region accounts for $3.3 million but no referral data was reported.	2,744	$5,713,039
Services By Other Mental Health Practitioners	25	$18,600
TOTALS	8,280	$6,114,739

SPECIAL COMMENTS:

1. DMH-DD Grant-in-Aid Agencies utilize fees charged to clients on a sliding scale based on family size and income level. Certain services are also covered by the DPA Green Card. In addition, in some cases families may have Health Insurance Benefits with psychiatric coverage. Regions report some confusion with respect to these practices, particularly in reference to those services considered "free of charge" as understood by them in their interpretation of the previously cited Policy Memoranda.

2. Some DMH-DD Grant-in-Aid Agencies feel that DCFS Guardianship implies total DCFS financial responsibility for wards referred for their services.

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